MASSACHUSETTS 
NURSE

The Massachusetts Department of Public Health, with the support of the hospital industry, has approved a policy to allow patients to be boarded and cared for in hallways and corridors outside inpatient units as a means of dealing with emergency department overcrowding.

The MNA Board of Directors has carefully studied this policy and its implications for patient care and nursing practice. The Board has issued a position statement opposing this practice because boarding patients in hallways will endanger patients and result in degrading and substandard care; violate patients’ rights to dignity and privacy, including numerous HIPAA violations; violates fire safety codes; violates numerous infection control standards; and violates the Nurse Practice Act, nursing standards of practice, as well as professional ethics. See Page 11 to review the executive summary of the position statement, and visit the MNA web site at www.massnurses.org to review the complete position statement, as well as to obtain detailed information on the policy and actions MNA is taking to stop it from being implemented.

Survey finds doctors concerned that RN understaffing harms patient

A landmark study of physicians in Massachusetts released on April 26 indicates poor RN-to-patient ratios in hospitals are resulting in significant harm and even death for patients. According to the survey, physicians rank understaffing of registered nurses as the biggest problem in Massachusetts hospitals directly affecting patient care. Fully 78 percent of physicians report staffing levels in hospitals is too low, with devastating results for their patients:

- Alarming results: 1-in-5 physicians report patient deaths attributable to nurses having too many patients to care for.
- 82 percent agree the quality of patient care in hospitals is suffering due to understaffing.
- 61 percent report medication errors, such as improper medication or dosages due to understaffing.
- 54 percent report complications or problems for patients due to understaffing.
- 43 percent report poor staffing leads to longer stays for patients.
- 37 percent report injury or harm to patients due to understaffing.

As a solution to the problem, 74 percent of physicians surveyed support legislation to set minimum RN-to-patient ratios.

Important safe RN staffing update

As the Mass Nurse went to press, there were two important developments in the campaign for safe staffing legislation:

- The safe RN staffing bill had been assigned its bill number for the 2005-06 session, (H. 2663) and was assigned to the public health committee.
- A legislative working group on nurse staff ratios was assembled by House and Senate leadership, which is charged with crafting a safe RN staffing bill to be brought to the Legislature for a vote.

All nurses are encouraged to visit the MNA web site at www.massnurses.org to find out what you can do to support this important development in our campaign to establish safe RN-to-patient ratios in hospitals.

Organizing: making your voice heard

Defend, include, empower, elect, strategize, mobilize—all words that help to define the multi-layered concept of organizing a union. From providing due process through grievance and arbitration procedures to empowering employees to have a formal say about their working conditions, union membership can make the difference between working for your rights and ensuring your rights are working for you.

This issue of Massachusetts Nurse takes a closer look at the benefits of organizing and it does so in a number of ways: with statistics, first-person commentary and historical information.

You will read about the significant differences between facilities that are unionized and those that are not. You will also hear the voices of a number of nurses who have been both with and without union representation. You will learn about the origins of organizing and how federal laws first enacted nearly a century ago still impact today’s unions. You will gain knowledge of the role legislative activism plays in the organizing process and ways in which it can become more involved in the development of your daily working conditions.

Special to this issue is a narrative chronicle from one of our associate directors of organizing, whose call to action has led her to a number of picket lines and a personal understanding of the true meaning of solidarity.

Another highlight is an interview with award-winning health care journalist Suzanne Gordon, whose new book addresses managed health care and its undermining effects on nurses and patients. A new column spotlighting MNA members “in the news” is introduced and thought-provoking information is delivered in a synopsis of a thesis which asks and positively answers the question “Is MNA a lifeline for Massachusetts nurses?”
Sen. Tolman and Rep. Hynes honored at annual Dr. Benjamin Gill awards

The Seventh Annual Dr. Benjamin F. Gill Memorial Award Reception held March 19 at the Hotel Radisson in Cambridge honored Sen. Steven A. Tolman and Rep. Frank M. Hynes for their work and continued efforts in fighting for a single payer health care system in Massachusetts.

As the debate over how to expand health insurance coverage in Massachusetts intensifies, activists from across the commonwealth who are engaged in the fight for fundamental health care reform gathered in Cambridge to honor the memory of the late Dr. Ben Gill. Gill was a psychiatrist who devoted his retirement years to making universal health care a reality. The award recognizes a person or persons who have made a significant contribution to the cause in which Dr. Gill believed so passionately.

The recipients this year were two outstanding legislators and the lead sponsors of the Massachusetts Health Care Trust legislation, Sen. Steve Tolman and Rep. Frank Hynes. Quentin Young, coordinator of Physicians for a National Health Program, traveled from Chicago to deliver the keynote address.

The Massachusetts Campaign for Single Payer Health Care (MASS-CARE) and the Universal Health Care Education Fund (UHCEF) jointly sponsored the event. MASS-CARE is a coalition of over eighty local and statewide organizations, including MNA, that have united to press for passage of the Massachusetts Health Care Trust bill, legislation to create a universal, single-payer healthcare system for Massachusetts. UHCEF is MASS-CARE’s nonprofit [501c(3)] partner, educating Massachusetts’ residents about the unjust underpinnings and practice of the current system.

Barbara Ackermann, chair of UHCEF and former mayor of Cambridge, emceed the proceedings. During the event, the Joseph Lillyman Ensemble, whose members belong to the Consortium for Psychotherapy in Concord, entertained guests. Regrettably, Peg O’Malley, RN, MASS-CARE’s chair, was under the weather and unable to participate.

Receiving the award on behalf of Rep. Hynes (the lead sponsor of the legislation in the House) was his legislative aide, Lincoln Heineman. Due to a long-standing prior engagement, Representative Hynes was unable to attend.

Honoring Frank Hynes underscored the intricate relationship between the integrity of the nursing profession and the building of a just healthcare system. In 2000, Rep. Hynes co-chaired the state commission studying the crisis in the nursing profession which recommended mandatory, minimum RN-to-patient ratios. Several years ago MNA created the Frank M. Hynes Award to recognize the contributions of deserving Massachusetts freshman state legislators or municipal officials who clearly demonstrate exceptional contributions to nursing and health care.

Sen. Dianne Wilkerson presented the award to her colleague and friend Steve Tolman, the bill’s lead sponsor in the Senate. Wilkerson spoke eloquently of Tolman’s indefatigable efforts to educate and build support among Republicans as well as Democrats, among representatives as well as senators. Tolman extolled Wilkerson’s tireless efforts on behalf of her constituents and all Massachusetts’ residents, and spoke passionately of Frank Hynes’ integrity and knowledge. He also urged the crowd of activists to fulfill their mission and help get the Health Care Trust passed in 2005.

Dr. Quentin Young, a 40-year advocacy veteran in his quest for national health care, brought humor and compassion to the podium. He agreed with MASS-CARE that the current political climate within the DC Beltway does not bode well for passage of legislation by Congress to begin the transition to single-payer universal health care. Instead, he said, it will begin in the states and prove that a single risk pool is cost-effective and quality-enhancing. The motto of the campaign is, “Everyone in, nobody out.”

As Young put it, “The first part of this slogan describes the legal structure of single payer, while the second part is its ethical imperative.” With the Vermont Legislature poised to enact single payer enabling legislation, the race is on to see which state will be the first to launch a high-quality, universal, portable, publicly financed, democratically accountable system.

Dr. Patricia Downs Berger reported that MASS-CARE’s Legislative Committee has prepared a petition for grass roots supporters to use as they build political pressure on legislators to support change. A sample petition is part of this article. Other copies of the petition and information on how best to use it can be obtained from the MASS-CARE office and will soon be available on its Web site, www.masscare.org.

Honoring Frank Hynes underscores the intricate relationship between the integrity of the nursing profession and the building of a just healthcare system.

Single Payer Petition (sample copy)

The Undersigned Citizens of the Commonwealth Desire the Passage Into Law of A Single Payer System of Health Care

This single payer system will make affordable, high quality, comprehensive health care available to everyone because it will eliminate the huge administrative waste characteristic of multi-payer and for-profit systems. The Trust will be funded with federal and state money, as well as with individual, family, and employer premiums collected by the Massachusetts Department of Revenue. There will be no co-pays, deductibles, health insurance premiums, or other out-of-pocket expenses. The Trust will control the system’s overall cost with efficient administration.

Therefore it will mean:

• high quality health care for Massachusetts residents
• health care as a right, not as a shrinking, job-dependent benefit
• facilitating preventive care, early diagnosis, and treatment for all
• eliminating overuse of expensive emergency care now used by the uninsured and underinsured who delay seeking treatment for financial reasons
• freedom to choose one’s own doctor
• money spent on patient care instead of on excess profits and paperwork

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Return to MASS-CARE -- 8 Beacon St., Suite 26, Boston, MA 02108 -- FAX: 617-723-7002
E-Mail: masscare@aol.com, call: 617-723-7001 or visit: www.masscare.org
Legislate for the real stakeholders—nurses and patients

By Julie Pinkham, RN
MNA Executive Director

Julie Pinkham’s column this month is taken from remarks made at the March 30 forum “Nurse-to-Patient Ratios: Research and Reality" presented at the Federal Reserve Bank in Boston, during which she unveiled the MNA’s latest research on the experiences of a number of patients recently treated in Massachusetts hospitals. Those findings appear on Page 14 of this issue of Massachusetts Nurse.

I am here today to represent two stakeholders who we believe have the most to win or lose in the outcome of this debate: the real leaders of patient care—bedside staff nurses; and, most important of all, the patients and families they care for every day, 24/7 in our state’s acute care hospitals.

In anticipation of this forum, we commissioned a statewide survey of Massachusetts hospital patients and/or their family members who have experienced a hospital stay in the last two years. The telephone survey of 200 patients was conducted by Opinion Dynamics Corporation, one of the nation’s leading research and polling organizations.

We believe this is the first statewide survey of its kind in the commonwealth to look at patients’ impressions of the quality and safety of their care in direct relationship to their experience with nursing care and nurse staffing levels.

In this survey, past patients overwhelmingly identify registered nurses as having the greatest impact on the quality of patient care in hospitals. Based on the total number of annual hospital stays in Massachusetts, Opinion Dynamics estimates that approximately 255,000 patients per year feel their safety is compromised by a lack of the availability of a nurse and more than 244,000 patients experience a compromise in the quality of their care. As an organization of direct care nurses, we find these numbers to be nothing short of shameful for a state that bills itself as a Medical Mecca.

More importantly for today’s discussion, by an overwhelming 3 to 1 margin, patients think it is time for the state’s hospital executives to back up staff nurses’ judgment and pass the bill implementing safe staffing ratios, H.2663.

These are the voices that are not being heard or heeded by the hospital industry. There is real pain and suffering behind these numbers. When a patient reports a nurse took too long to deliver a medication, picture someone you know with bone cancer writhing in excruciating pain waiting for relief. And if you can’t, I can—that was my late sister in-law’s experience at Mass. General Hospital. When a patient reports a delay in eing in excruciating pain waiting for relief, they deserve to be moved from units where nurses are overburdened.

Now is the time to get involved in the MNA!

Correction
A page one article (“Salem Hospital nurses vote for MNA union representa- tion”) of the April Massachusetts Nurse neglected to include Merriam Valley Hospital in a list of MNA represented hospitals located on the North Shore. We apologize for the oversight.

Get involved! MNA members who run for office have an active voice in the association—your voice counts! You may choose to run for a seat on the MNA Board of Directors, the nominations or bylaws committees, or one of our six congresses addressing issues related to practice, policy, health & safety or ethics.

We are appealing to members in good standing to run for office in the 2005 MNA General Election.

Regional Director, Labor*
Director at-large, General*
Director at-large, Labor*
Labor Program Member*
Nominations & Elections Committee
Bylaws Committee
Congress on Nursing Practice
Congress on Health Policy & Legislation
Congress on Health & Safety
Center for Nursing Ethics & Human Rights.

*General means an MNA member in good standing & does not have to be a member of the labor program. Labor means an MNA member in good standing who is also a labor program member. Labor Program Member means a non-RN Healthcare Professional who is a member in good standing of the labor program.

Interested members should complete the consent to serve form published on Page 17. Deadline to have your name placed on the final ballot is standing to run for MNA office in the 2005 MNA General Election.

A description of the responsibilities of each position is available on the MNA Web site at www.massnurses.org
Following is a summary of the status of collective bargaining at MNA units, listed by Region.

Region 1

Cooley Dickinson

The Nurses Committee has proposed a new vacation implementation system to the hospital in order to create a more equitable distribution of time off throughout the year. The committee is planning to place a “thank you” ad in the local papers to thank those legislators in western Massachusetts who have supported our Safe Staffing Legislation and to draw attention to those who have failed to sign on.

Berkshire Medical Center

The Nurses Committee has filed for arbitration regarding a contract dispute with the hospital over the implementation of the recently negotiated medical insurance coverage language. Money amounts communicated at the table regarding the costs to the bargaining unit were not implemented after the ratification of the contract. Discussions prior to the grievance procedure failed to reach a resolution. The hospital failed to bargain in good faith with the MNA. Now the entire MNA Negotiating Committee will stand before an arbitrator in order to bear witness to this deception.

Region 2

UMass Medical Center, University Campus/Private Sector

The nurses committee is presently engaged in bargaining over all the aspects involved in the lakeside expansion of the hospital. While the hospital has stated its plans to hire more nurses to facilitate this expansion, we are opposed to their plans of merging different nurses to the unit at the Hunt Center in Danvers.

Region 4

Salem Hospital

After recently voting in the MNA, negotiations were set to take place last month. The first MNA labor/management meeting on March 23 addressed a number of issues, including three outstanding grievances. An April labor/management meeting was scheduled for the RNs at the pediatric psychiatric unit at the Hunt Center in Danvers.

Somerville Hospital

The Somerville bargaining unit has instituted a bi-monthly dinner meeting, which started in January. At the March meeting, the group participated in a spirited discussion of the program, “Accept or Reject Assignment,” and a review of the safe staffing policy. The new contract is ready for signing.

Faulkner Hospital

The April 5 membership meeting discussed and voted on the new by-laws. The unit has a new associate director, John Gordon. John has been meeting with the former associate director and the members, and is getting up to speed on the important issues.

Norwood Hospital

The Norwood bargaining unit had a lively open meeting in March, reviewing staffing shortfalls and discussing plans to improve staffing. One unit acted immediately and, with the assistance of the co-chairs, got a section of their unit re-opened, adding at least one RN to its staffing plan.

Whidden Hospital

The unit has sent a re-opener to the committee in the process of preparing for contract negotiations. The unit is also working on rewriting the local by-laws, with the current committee looking to make some major changes. The chairperson has recently resolved numerous issues with CHA. There have been problems with instituting the new pay scale for both RNs and HCPs. The committee is pushing the hospital to clear up these problems.

New England Medical Center

Negotiations continue for a successor contract. The medical center agreed to implement a short-term incentive program, which provides for time and one-half or double time for extra shifts worked.

Correction

A Faulkner Hospital update appearing in the March issue of Massachusetts Nurse included incorrect information. The update should have said the bargaining unit was “working with the hospital to implement landmark floating language. Devised competencies to administer to RNs. RN will not be required to float if passed competencies.”

Region 5

Wachusett School Nurses

Contract negotiations were due to begin last month.

Leicester School Nurses

Preparing for contract negotiations to begin later this spring.

MNA on Beacon Hill

MNA-backed candidates win special elections to Mass. House

Three new legislators support safe RN staffing bill

With the support of nurses, three candidates vying for seats in the Massachusetts House of Representatives won their special election bids on April 12. Elected were Linda Dorcena Forry from the 12th Suffolk District (Dorchester, Mattapan and part of Milton); Michael Moran from the 38th Suffolk District (Allston/Brighton) and Chris Speranazzo from the 3rd Berkshire District (Pittsfield). All three are Democrats and won their state primary elections in March. Forry was unchallenged in the April 12 election, while Speranazzo and Moran won convincing victories. The three have pledged their support for the safe RN staffing bill (H.2663).
In solidarity: how the nurses at St. Vincent’s came together

By Deb Rigiero, RN
Associate Director of Organizing

In solidarity, I have used these words often, particularly when signing off on letters and fliers.

In the spring of 2000, the nurses at St. Vincent’s Hospital, Worcester, experienced the true meaning of “Solidarity.” On our strike line, along with the St. Vincent nurses, there were nurses from all over, as well as firefighters, police, carpenters, steelworkers, elevator workers, bus drivers, postal workers, food workers, community groups, political leaders and many others. We have a big book listing all those who came on the line, donated to our cause and supported us during our strike. You don’t realize how much it means until you’re on the receiving end of this solidarity. Broad-based support also makes management aware that a strike is perceived as a public issue, and deliver

It took courage to put the safety of patients first over the security of a weekly paycheck....Our community supported us every step of the way, helping to make our strikes the successes they ultimately were.

Organizing and the law: protecting your rights as a worker

By Eileen Norton
MINA Director of Organizing

In past issues of Massachusetts Nurse we have presented research that shows that pay, benefits and patient care are all better in unionized hospitals.

Do you think it is a coincidence that in non-union hospitals nurses receive pay increases when unionized nurses working in close proximity negotiate a contract with increased benefits?

Hospitals have been employing this union avoidance tactic for years. They believe it is all about the money, but you know that is not the case. Many of us have been nurses long enough to remember when nursing supervisors really cared about the nursing staff and were there to support them.

Do you remember when it changed? Now nursing managers support the view of the hospital and do all they can to protect the bottom line. Have you ever been told to “do the best” you can? Nurses without unions are on their own today, but they don’t have to be. When you work in a unionized facility you are not on your own. You have the protection of your contract and the support of your colleagues.

Of course I am not suggesting there are no problems in unionized facilities; we all know there are, but we also know that unionized nurses have a process to deal with problems that arise. You don’t have to fear losing your job when you advocate for safe patient care or for safe practice issues. You have a voice in all the decisions that affect you and the work that you do.

Workers have struggled for years to organize in their workplace so they would have a voice in improving their working conditions. Before we focus on organizing in healthcare and the issues really in Massachusetts, it would be helpful to first briefly list the federal laws that deal with organizing.

1918/National War Labor Board: The first significant federal attempt to help workers in their struggle to organize was in 1918 when President Woodrow Wilson set up a National War Labor Board. One of the principles adopted by this board gave workers the right to organize in trade unions and to bargain collectively through their chosen representatives. This policy was vigorously enforced and trade unions flourished.

1926/ Railway Labor Act: In response to several strikes in the late 19th century this act was passed by Congress in an effort to bring order. It was the first effort to develop a national labor policy. This act was expanded in 1936 to include airlines.

1932/The Norris-LaGuardia Act: It denied federal courts the right to issue injunctions in ordinary labor disputes. It also removed labor activities from the sanction of anti-trust laws and outlawed yellow-dog contracts. In passing this act, Congress noted for the first time the imbalance in power between the employees and their employer.

1933/National Industrial Recovery Act was adopted by Congress. It provided that fair labor standards were established by raising wages, shortening hours and eliminating industrial workplace democracy, child labor and other sweat shop practices. The act also provided that employees have the right to organize and bargain collectively, free from any interference, restraint or coercion. This act was declared unconstitutional by the Supreme Court in 1935 because it attempted to regulate business transactions not part of interstate trade. President Roosevelt subsequently hired lawyers to redraft a replacement, the Wagner Act.

1935/The Wagner Act. Formally titled the National Labor Relations Act, it covers private sector firms that are large enough to have an impact on commerce between states. Employees covered by the act were guaranteed the right to organize and bargain collectively through secret ballot elections and to bargain collectively through representatives of their own choosing. They also had the right to engage in concerted activities for the purpose of collective bargaining or other mutual aid or protection. In addition to these three rights, the NLRA listed unfair labor practices by employers, including financing of company unions (where management sets up a committee but retains full control, creating an illusion of workplace democracy), arbitrary dismissal of activists, refusal to bargain, blacklisting and employment of industrial spies. The Wagner Act had a significant effect on the labor movement in the United States. Private sector employees who previously were unprotected were now able to unionize and bargain collectively over wages, hours and conditions of work.

1947/The Taft-Hartley Act. Many saw this act as a way to restore the balance of power between management and labor; others saw it as returning the power to management. This law was actually a series of amendments to the NLRA and was formally known as the Labor Management Relations Act (LMRA). The amendments that were created restricted Wagner Act provisions providing protection for workers who were seeking to unionize and also provided regulations to restrain unions. The restrictive legislation that was imposed by the Taft Hartley Act remains in force to this day.

1959/The Labor Management Reporting and Disclosure Act, known as the Landrum Griffin Act. It contains elaborate reporting requirements for unions, particularly on the handling of money. It also provides a union member’s bill of rights to apply in matters such as union meetings, elections, eligibility for office, and union disciplinary proceedings. It also amended the Taft-Hartley Act further to clarify and close loopholes in the secondary boycott provisions, which further restricted the range of local union activity in the area of labor-management relations.

1974/Health care amendments: In 1974 the NLRA was amended to eliminate the exclusion of nonprofit hospitals and to bring...
**Labor Department: Educating Our Members**

The benefits of union membership: numerous and measurable

By Joe Twarog

Associate Director of Labor Education

What difference does it make to work in a union facility versus a non-union facility? Can the differences be quantified and measured?

The evidence illustrates that union workers earn more. Union members have better pension and health care benefits. Union members have better sickness and accident benefits. Union members have contractual protections for safety on the job. Union members have better job security and protections from discretionary actions by the employer. Union members have a voice in their workplace.

Union members have access to a grievance and arbitration procedure to challenge contract violations and unfair treatment. Union members can advocate for their patients and quality health care in a real and enforceable manner.

And, in addition to all of the above, according to a recent study published in the Journal of Nursing Administration (March 2004, vol. 2, No. 3), specifically patients suffering a heart attack, have better outcomes in a union facility compared to a non-union facility.

While there are some laws that affect workers' rights, such as minimum wage, OSHA, FMLA and ERISA, these are regarded as the floor in union facilities. That is, the union views these legal rights as the starting point from which to bargain better benefits above and beyond what the laws provide. However, in non-union facilities, these laws are most often the ceiling. These laws are it. End of story.

According to the U.S. Bureau of Labor Statistics, the difference in median weekly earnings for 2004 shows that there is a 27 percent wage advantage in union facilities (all industries, public and private) over non-union facilities. Furthermore, the union wage advantage (all based on median weekly earnings), for women is 33 percent, for African Americans is 35 percent, for Latinos is 51 percent, for Asian American is 35 percent, for Latinos is 51 percent, for Asian American is 11 percent.

The U.S. Department of Labor, National Compensation Survey for Employee Benefits in Private Industry (March 2004) illustrates the differences in benefits (see chart at right).

It is therefore clear that being unionized makes a world of difference, in clear and measurable ways. The differences are dramatic. Furthermore, the benefits of unionization extend well beyond those of simple self-interest. The contract and the union make a difference in the lives of its members, as well as a difference in the patients they care for and serve.

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Joe Twarog

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**Benefit comparison, union and non-union workers**

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<td>Guaranteed pension (defined benefit)</td>
<td>70%</td>
<td>16%</td>
<td>54%</td>
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<tr>
<td>Medical care benefits</td>
<td>89%</td>
<td>67%</td>
<td>22%</td>
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<tr>
<td>Short-term disability coverage</td>
<td>67%</td>
<td>36%</td>
<td>31%</td>
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<tr>
<td>Life insurance coverage</td>
<td>63%</td>
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Source: U.S. Department of Labor, National Compensation Survey for Employee Benefits in Private Industry

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...Solidarity

From Previous Page

impact on our day-to-day lives. I would read about pickets and strikes; I would also do my own personal boycotts (grapes, strawberry Coors beer, etc.) to feel that I was at least participating in my own small way. After being on strike, I realize that every worker's struggle is our struggle and our struggle is every worker's struggle. City workers picketing so the city will not raise their insurance rates can directly impact our ability to negotiate our insurance rates. The St. Vincent's nursing and Brockton nurses' struggles stem from the fact that is taking a stand against the unjust and unfair treatment of workers.

Since our strike, many nurses at St. Vincent's have participated in other union strikes and pickets. I remember going to a picket at Raytheon and hearing the shouts of "the nurses are here!" as we crossed the street to the picket line. In California, we stood at an Albertson's strike line for 30 minutes. We walked away feeling even those 30 minutes made a difference. Standing on the strike line with the Worcester Saint Gobain workers or bus drivers helped me appreciate the courage and sacrifices these workers are making. You feel you are part of a brotherhood or sisterhood that is taking a stand against the unjust and unfair treatment of workers.

You've all taken the first step in becoming an active member. You've organized and are a union. You have a real voice in the workplace. The next step is to maintain and nourish the contacts that you have within your community. The St. Vincent's nurses are part of the Central Massachusetts Labor Council. We send delegates to the council meetings. They hear our issues and we hear their issues. We have mutually supported each other through job actions, letters, phone calls, and other methods.

When you are at a political function, let legislators know what is happening in their community. They are here to listen and help. It is more important to talk to your local legislator, 20 minutes on a picket line, a letter to the editor or a meeting a month. Every little bit helps. It is better for your bargaining unit to have a lot of people spending a little time, than a few people spending a lot of time working toward a common goal.

At this I leave you with two thoughts. The first is don't drive by a picket line without stopping, even if it is just for five minutes. Five minutes out of your busy day is priceless to the workers on the line. The second is a quote from Martin Luther King, Jr.: "All love is interconnected. All men are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly."
the private, not-for-profit health industry under the jurisdiction of federal labor law. It included a definition of “health care institution,” which was broadly defined to include “any hospital, convalescent hospital, health maintenance organization, health clinic, nursing home, extended care facility, or other institution devoted to the care of sick, infirm or aged person(s). Related amend-
ments designed to meet what was felt to be the special problems of health care institu-
tions were also adopted.

1. Nurses were assured the right to strike; however, to ensure continuity of care, a 10-day notice had to be given to the employer.

2. Provision for federal mediation, by the federal Mediation and Concili-
tory Service.

3. Created Board of Inquiry, which allows mediators to delay a strike for a 60-day cooling off period, if deemed a patient safety issue.

The health care amendments were the last significant change to the NLRA.

Prior to the federal healthcare amend-
ments, states were left to their own discretion. Massachusetts had its own state labor law, which allowed employers in hospitals to organize. Under state law, you did not have the right to strike. The health care amend-
ments to the NLRA in 1974 supersede state labor law and brought private, nonprofit healthcare facilities under federal jurisdiction which provided employees the right to strike and

be made to the NLRA must be made at the federal level, where labor has historically had difficulty exerting enough influence to make changes.

The U.S. system, unlike other industrialized countries, can make it extremely difficult to organize workers. Though workers clearly have the protected right to form a union, the time it takes to process anything under the system, as well as employer campaigns, have proven in many cases too difficult to overcome.

Successful organizing requires over-
coming many obstacles, but it has been proven that when workers unite together for the common good, anything is possible. Employers will use any and all tactics they can to control the workplace and to prevent you from organizing. One tactic is to create management-dominated committees, (i.e. shared governance and magnet committees). These committees give the impression that employees have a voice, but in reality, man-
agement retains all the control and makes all the final decisions. Workers can never exercise their voices within the confines of a management-dominated committee. True participation requires that management accept the legitimate role of unions and the capacity of workers to negotiate the terms of their workplace. Ask yourselves why man-
agement fights so hard and spends millions of dollars to thwart unionizing efforts? It is because once unionized and empow-
ered workers are a force in the workplace, management can no longer make unilateral decisions that affect you and the work you do. You become an equal partner, you have a seat at the table and you have a legally bind-

contract.

It is unlikely given the history and the state of our country today that any sig-
nificant labor law reform will occur in the near future. It is important, therefore, that we develop strategies that will work within our legal framework. At MNA we have adopted and believe in the union building model of organizing—sometimes referred to as rank-and-file organizing or one-on-one organizing. It is a model that believes in involving all the members of a bargaining unit and builds the union before the actual vote occurs. The union building model of organizing was devised to combat the consultant campaigns that are waged by employers. This model increases the likeli-
hood of success because it generates worker participation and the commitment necessary to withstand the typical aggressive employer anti-union campaign.

A commitment to running this type of campaign is also a commitment to having a union where members expect and demand a more active role in the decision-making pro-
cess of the union. By empowering members from the beginning of an organizing cam-
paign you enable them to become stronger and to know without a doubt that they are the union. Once empowered, there are no limits to what members can achieve.

Organizing

From Page 5

The MNA this spring sponsored three educational programs for senior nurs-
ing students entitled “The Real Nursing World—Transition from Student to RN.” The programs were designed to provide senior nursing students with strategies for the transition from student to professional nurse and offer an exclusive job fair for new graduate nurses. The programs were held March 31 in Springfield, April 5 in Worces-
ter, and April 8 in Randolph. The MNA has

hosted this program for sev-

eral years, but this year’s effort allowed more than 500 senior nursing students to share in this exciting opportunity and take full advantage of a timely learning experience. Planning has begun for the 2006 Transition Programs, slated for next April. For more information, contact Carol Mallia RN, MSN, associate director, Department of Nursing at 781-830-5744 or cmallia@mnarn.org.

Programs held in Springfield, Worcester, Randolph

More than 500 senior nursing students participate in MNA’s transition programs

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eral years, but this year’s effort allowed more than 500 senior nursing students to share in this exciting opportunity and take full advantage of a timely learning experience. Planning has begun for the 2006 Transition Programs, slated for next April. For more information, contact Carol Mallia RN, MSN, associate director, Department of Nursing at 781-830-5744 or cmallia@mnarn.org.

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Political connections and organizing campaigns

By Jeanine Hickey, RN
Associate Director/Organizer

Developing political connections and alliances is a key component in any campaign, whether it is a union organizing campaign, a campaign seeking public policy changes, or a direct action campaign for social justice. Building political relations is one of the most important aspects of any organizing campaign involving the nursing profession and the health care industry.

Beth Wilson, Associate Director/Organizer, the MNA Director of Legislation and Government Affairs has so aptly stated to many MNA members, “Everything you do as nurses and health care professionals is directly related on some level to a government process or agency.” Whether it is on the local, state or federal level, every aspect of a nurse’s job is regulated by one of these legislative bodies. That is why it is very important for nurses to establish connections with their elected officials before there is a pressing issue.

Political activism is important for unions. In the past several years, the MNA has worked hard to educate members about the importance of political connections and legislative activism. As frontline registered nurses, we know full well the challenging conditions we face in our daily practice. That is why we must be at the forefront in educating our legislators on the effects those conditions are having on our patients and our professional practice. If we don’t take the lead in getting our message out, the legislature, you can be assured that the only message they get will be from the hospital industry. As we all know, it is not the same as ours.

We have come a long way in the past several years in making our voices heard on Beacon Hill. MNA members have become actively involved in lobbying elected officials on the local, state and federal levels through phone calls, emails, letter writing and office visits. In addition, many members have worked on legislative committees, attended legislative briefings and attended legislative briefings. It is through these efforts that nurses have made political connections that have proved to be beneficial for their bargaining units and for the Association.

Another example is the focus of the effort to mobilize nurses has been the passage of safe staffing legislation (H.2663). A key reason it was so important for their own bargaining unit fights over mandatory overtime, nursing practice issues and campaigns to save their hospitals from closure.

The importance of having established political connections became clear during the strikes at St. Vincent’s Hospital, Worcester, and Brockton Hospital. Nurses in both bargaining units courageously fought against unsafe staffing conditions and mandatory overtime. In both cases the bargaining units were able to call upon existing political alliances for support and to expand their contacts to include a broader perspective, from the local and state level right up to the federal level. These contacts were instrumental in settling both high profile strikes.

In the case of St. Vincent’s, the direct involvement of Sen. Edward Kennedy and Rep. James McGovern brought the hospital and MNA bargaining unit nurses together in Washington to negotiate a settlement to the nurses’ 49-day strike. These negotiations led to landmark contract language that set strict limits on the use of mandatory overtime and gives a nurse the explicit right to refuse a mandatory overtime assignment if he or she were too fatigued or ill to work safely.

In May 2001, the nurses at Brockton Hospital went on strike to protest the hospital’s failure to provide sufficient staff and resources to offer safe patient care and garnered national attention for their campaign. “They refused a means of staffing the hospital. Like their colleagues at St. Vincent’s, the bargaining unit nurses established political contacts on a political level. On Aug. 24, 2001, an agreement was reached to settle the strike after Sen. John Kerry facilitated a marathon negotiating session. Two important provisions of the settlement were an obligation to the patients and the nurses to keep the hospital and language that set strict limits on the use of mandatory overtime and inappropriate floating.

In addition to these struggles, MNA members have reached out politically in their campaigns to keep health care facilities from closing. MNA members engaged local and state politicians in their efforts to help save several hospitals: Whidden, Waltham, the Fernald School, Worcester State and Hale Hospital (now Merrimack Valley Hospital).

One example of the MNA nurses’ efforts to fight hospital closure was the campaign to save Hale Hospital in Haverhill. In this campaign, because the Hale was a municipal facility, every aspect of the sale needed to go before local and state legislative bodies. MNA nurses, working in coalition with other unionized employees at the Hale, lobbied elected officials over a two-year period to keep Hale open and, secondarily, to protect the pensions of hospital workers.

The political work done by the Hale nurses in conjunction with other employees and advocacy groups was instrumental in keeping the hospital in service so it could be sold and remain in business. The political connections the nurses made in this campaign led to the development of long-term alliances with their local legislators and proved to be instrumental lobbying efforts, like the safe staffing initiative.

As we face the professional challenges and uncertainties of a health care system in jeopardy, the importance of forming political connections becomes more important than ever. Nurses have credibility in the public policy arena when speaking on nursing and health care issues. We must continue to develop political connections to keep political connections to continue to be at the forefront of shaping public policy. So, if you want to be a part of the voice of change, you need to GET POLITICAL!

How can you get political?

- Go to the MNA Web site www.massnurses.org and click on the legislative and government link for a comprehensive list of activities and information on the legislative process.
- Get educated on the issues.
- Call or write your legislator and let him or her know your views on the issues that affect your daily working conditions and your nursing practice.
- Attend a legislative briefing in your area.
- Volunteer to campaign for an area legislator.
- Contribute to the Mass Nurses-PAC.

These are just some of the ways you can get political. Just know that you can make a difference, no matter what level of activity you choose to participate in.

As Margaret Mead said, “Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed it’s the only thing that ever has.”

Imagine what a powerful message we could send if we all got political!

MNA: A lifeline for Massachusetts nurses

When Beth Wilson began research for a master’s thesis her primary objective was to provide a “Political connections and organizing campaigns framework” for union nurses. The nurses, Wilson, was the Political connections and organizing campaigns Coordinator/Economic Analyst in the Nutrition Division of the Massachusetts Department of Public Health ultimately came to the conclusion in her thesis titled “A Lifeline? Is the Massachusetts Nurses Association Able to Shield Massachusetts RNs from Healthcare Industry Restructuring?” that indeed membership in the MNA serves as strong support, but more non-union nurses and in particular, nursing students, must be educated about the advantages of organizing.

Wilson, who presented her thesis at UMass-Lowell in April of 2004, points to a hospital and health care system “in flux” resulting from the past 30-year period when efforts were made to control costs through deregulatory measures. Cost-cutting changes translated into restructuring methods borrowed from industry—shakeup effects that exacerbated hospital mergers, consolidations, integrations and downsizing and generated increasingly unsafe working conditions for nurses.

And so the domino effect began. Nurses left the hospital setting, creating a shortage and further strains from remaning RNs. As a result, more nurses were mobilized to the MNA and become members. In 1994, at the behest of its members, MNA initiated its Safe Care Campaign, a drive that propelled its status to one of national significance. The issue of nurses staffing and patient care and brought the issue of nurses unionizing into the forefront. Now, years and many bargaining units later, MNA has continued to strengthen its membership. But even as more nurses have become aware of the advantages of belonging to a union, the bottom line question to Wilson’s thesis generated a contradiction in response.

Through working with working conditions, facility reorganization, patient care and job satisfaction of unionized and non-unionized RNs, Wilson attempted to determine whether unionized RNs maintained more positive working conditions. As it turned out, her survey said one thing and one-on-one interviews with nurses said another.

The survey (65 delivered over a four-week period) was completed by 49 non-union nurses and 19 by non-union nurses) indicated that non-union nurses had “more positive working conditions, patient care, and job satisfaction, with less facility reorganization and migration than unionized nurses.”

According to Wilson, the broad format of the survey allowed nurses to answer “without much reflection on past experiences.”

These nurses interviewed, however, had a brighter opportunity to reflect on their experiences, both good and bad. Interviews allowed Wilson to go “beneath the surface and discover that the supposedly better conditions of non-union nurses were a mirage.”

What Wilson discovered was that without a basic understanding of the political, economic, historical and ideological structure framing the hospital and healthcare systems, non-union nurses did not have a clear understanding as to why they were facing higher patient loads and increased work assignments. They talked of the decline of their working conditions up to patient-related factors, such as poor diet, lack of exercise, an aging population and lack of access to insurance. What these non-union nurses were not familiar with was the growth of managed care changes, insuror reimbursements, and the ramifications of years worth of cost containment measures.

The nurses interviewed, however, were also direct on the political influences of health care. They were aware of the big business hospitals had become and were not fearful of telling the public and the Legislature the affects that undermining conditions had on patient care and the nurses.

So, according to Wilson, therein lay the contradiction between her survey and personal interviews. While the survey indicated non-union nurses saw diminished conditions as their fault, union nurses were aware of what was really going on. While four out of five non-union nurses interviewed did not see the benefit of joining the MNA, these same nurses were also not aware of political connections that MNA has passed or is in the process of making law. A false consciousness prevailed, according to Wilson’s thesis, bringing her to the conclusion that “new ways” are needed to disseminate information about joining the union and the positive actions such a measure will engender.

But, according to Wilson, the MNA “can not do it all.”

She concludes that nursing education must be expanded. Currently students are taught how to care for patients, but when it comes to providing critical information about the political economy of health care, instruction stops short.

In addition to “giving non-union nurses the tools to be self-aware,” Wilson points to the need for a national health care reform, and calls for the adoption of universal health care.

“Hospitals should focus on patient care standards, not reimbursements and market share,” she writes. “The insurer oligarchy must be legislated and the unregulated mentality so pervasive in today’s society must be removed from health care.”
Can joining a union really change the future for my patients? Yes!

Ask some of the more than 22,000 nurses and health care professionals who make up the MNA what it means to be a member of a union, and you hear a common theme repeated in their answers. “It’s all about the patients,” explains Edith Harrigan, an RN at St. Vincent Hospital in Worcester for 35 years. “Organizing a union within our hospital is letting us take our practice back and, as a result, we’re getting closer to providing the level of professional nursing care that our patients need and deserve.”

It is this spirit, this mentality, this desire, that has led hundreds of thousands of nurses and health care professionals throughout Massachusetts to organize a union within their place of employment.

“The process of organizing was pretty scary at times,” says Harrigan, adding that the union at St. Vincent completed its long drive to organize in 1998, and that it didn’t sign its first contract until after a 49-day strike. “But what was scarier was what would have happened if we didn’t organize. We just couldn’t do it anymore. We couldn’t let management put us in the position of providing substandard care to patients—and we knew we couldn’t change things without the strength of the MNA.”

The union myth

Although it is commonly believed by some audiences that the sole purpose of a union is to improve the wages and benefits of its members, this is only a small part of the picture.

Union members—and MNA members in particular—select to “organize” so they can improve their workplaces across a spectrum of issues. For most MNA members, these issues have included inadequate staffing, mandatory overtime, the lack of proper orientation for new and “floating” nurses, and other professional concerns.

By organizing an MNA bargaining unit at their places of employment, members create, grow and use “a real voice”—or a voice grounded in solidarity that will influence change. Organizing a union also lets members join forces with millions of other professionals, and they in turn can use this power to influence important changes at both the state and national levels.

“We tell nurses that in today’s health care environment it is more important than ever to have a union at their facility,” explains Eileen Norton, director of organizing for the MNA. “With the current staffing shortages in health care facilities, we need to have an effective voice. You need to be part of the decision-making process so that you have a say in everything that affects you and the work you do.”

Norton adds that as the unionized nurses become more vocal about their working conditions, management responds with strategies that make them believe they have a voice in what is happening.

“They use nurse councils, task forces, shared governance, quality circles, committees to redesign the workforce and, of course, the latest ploy, ‘magnet status,’” says Norton. “These approaches only work as long as we are fighting the right fight that affects you and the work you do.”

Although Brosnihan didn’t realize it at the time, the MNA’s organizing department was quick to recognize the CEO’s actions as behavior in violation of labor law—and the CEO’s realization was scary because there was no hiding after that,” says Starbard. “But I couldn’t turn back. Management’s behavior was just too infuriating, and it was hurting patient safety.”

The highs and lows

For the nurses at UMass Memorial Hospital in Worcester, the need to organize became undeniably apparent in 2001—right as the hospital’s then CEO was dramatically cutting benefits and mandating overtime at an alarming rate.

“The administrators at our hospital wanted to manage patient care like they were counting beans,” says Jackie Brosnihan, an RN at UMass for 30 years and chairperson of the hospital’s MNA bargaining unit. “They were only looking at the bottom line and they were doing so at the risk of their patients and nurses.”

“We weren’t looking for anything from the hospital other than the ability to do our jobs the way we were trained to,” adds Lynne Starbard, also an RN at UMass and co-chairperson of her bargaining unit. “So people started asking questions: listening to what was going on; paying attention to potential opportunities that might provide us with the right opportunity to organize. This was hard though because, at the time, most people were afraid of management.”

But two such opportunities came up when the hospital’s CEO “opened the flood gates” so to speak.

“Word began to spread that we were working with the MNA, and it didn’t go over well with management,” says Brosnihan. “In fact, the CEO showed up on my floor one day and, in a moment of arrogance, threatened time for being one of the faces of the organizing movement.”

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“Management brought in a new model called ‘patient care re-design,’ which meant more support staff, but also meant a much higher RN-to-patient ratio,” says Pellegrino. “Basically, they were selling us a bill of goods. The ratios increased to seven to nine patients per nurse and it failed miserably because patient safety was compromised.”

For the nurses at St. Vincent, this was the proverbial straw that broke the camel’s back. “A group of us took our concerns directly to the MNA,” adds Pellegrino, “and we held our first organizing meeting in 1996. I went to that initial meeting thinking there would just be a few people, but I couldn’t find a parking spot. There were more than 100 people there. That’s when I knew that something big was going to happen.”

Pellegrino and Harrigan both recall the highs and lows of establishing an MNA bargaining unit at St. Vincent and signing that first contract. Those highs and lows included two long years and a 49-day strike that was overwhelmingly voted in favor of due to management’s refusal to include mandatory overtime language in the contract.

“The day after we finally got the contract,” describes Pellegrino, “I walked into work and, while everything was the same, it was not the same. I walked in with my head held high because I felt empowered. We finally had a say in the care we provided for our patients.”

Strength in numbers: Nurses represented by MNA have successfully staged job actions to obtain better work conditions. RNs at St. Vincent’s Hospital in Worcester held a candlelight vigil in 2001 (above); nurses at St. Elizabeth’s Medical Center (left and below) picketed last year.
Nurses in the News

Massachusetts Nurse will put a spotlight on MNA nurses and whose actions have garnered media and public attention. From nurses who have petitioned administrators against staffings cuts to those who have appeared on television to address workplace violence, to bargaining units that have experienced victory at arbitration... MNA and its members are in the news.

MNA members appear on TV 4

MNA President and RN Karen Higgins and MNA members and RNs Barbara Cooke, Donna Kelly-Williams and Sandy Ellis were featured in a March 14 broadcast on TV 4’s “Women’s View” with anchor Lisa Hughes. The lively session featured the four healthcare professionals discussing their views on nursing, the current staffing crisis and importance of the passage of the MNA sponsored Safe Patient Care Act, currently before the Legislature. The proposed bill would set flexible minimum patient-to-nurse ratios in hospital settings.

NARH arbitration victory

An independent arbitrator’s ruling released in late February decreeing that North Adams Regional Hospital can no longer admit “more patients than nurses can safely care for” was the subject of two front page articles in Berkshire Eagle. On March 13, both the North Adams Transcript and the Berkshire Eagle gave top billing to the first of its kind ruling to deal with the issue of RN staffing and a hospital’s obligation to assign patients based on nurses’ ability to meet their professional practice standards. Quoted in both articles was Mary McConnell, RN, chair of the nurses’ union at NARH.

Proposed cuts at Good Samaritan in Brockton

Staffing cuts recommended by a health care consulting firm at Caritas Good Samaritan Medical Center in Brockton made front page news on March 18 in both The Enterprise and The Patriot Ledger. Quoted in The Enterprise article was Karen Gavigan, co-chairwoman of the MNA and a nurse at Good Samaritan for 15 years who said the recommended slashes would “affect every area, causing delays and waits in the emergency room.” More than 500 employees, doctors and patients signed a petition to oppose the staffing cuts in peri-operative services, a petition that was delivered to the hospital CEO, resulting in a two-week moratorium on the cuts while a task force looked into alternative efficiency-increasing options.

FMC contract fight makes print

Nurses at the Franklin Medical Center, struggling to maintain their current health insurance benefits in a new contract now under negotiation between hospital management and the MNA were the subject of articles appearing in both the March 2 - 9 issue of West County News and the March 19 edition of The Recorder. Joanne Caloon, an FMC nurse and bargaining unit co-chairwoman, was quoted throughout both articles, saying a small compensatory wage increase placed on the table by management would not nearly make up for additional health insurance costs sought by the hospital. Currently, FMC nurses working at least 24-hours a week are considered full-time, compared to the 36-hour work week deemed full-time at most hospitals. FMC management, in the contract now under negotiation, wants to re-define full-time to 36 or more hours a week. Following publication of the newspaper articles, several FMC nurses had letters to the editor published, keeping the story alive over a period of several days.

RN-to-patient bill gets press

An MNA sponsored press conference held March 22 at the State House showcasing results of a statewide survey that says 76 percent of those polled favor MNA sponsored legislation (Safe Patient Care Act) for improved nurse-to-patient ratios over a competing bill proposed by the MNA (Massachusetts Hospital Association) prompted a March 23 article in The Telegram & Gazette. Quoted in the article was MNA Executive Director Julie Pinkham as saying hospital officials “are unwilling to turn away patients or divert them to another hospital because it would be a loss of revenue.” The article points to the MNA’s criticism of the Massachusetts Hospital Association’s “Patients First” initiative and the union’s charge that the critical care unit at the hospital often has RNs caring for three or four patients, a violation of state regulations that call for a maximum 2-1 patient-nurse ratio in such units. In the article, Bronnihan calls the alleged violation “a budget issue.”

RN elected to public office

Deb Rigiero, RN and an organizer with the MNA was elected April 5 to the Leicester Board of Health, taking the seat from the incumbent by a 2-1-margin.

MNA nurse gives first person account

RN Charlene Richardson provided The Salem News with a first person account of the effects a March, 2003 on-duty assault has had on her life and work. Originally written for and appearing in the April issue of The Massachusetts Nurse, the compelling piece chronicles the act of violence perpetrated against Richardson while on duty as an ED nurse at Beverly Hospital. Richardson was indecently assaulted by a 50-year-old man who had been brought to the hospital for treatment. The perpetrator, who was convicted of indecent assault and battery, was sentenced to 18 months in jail. While Richardson remains a nurse at Beverly Hospital, she no longer works in the emergency department.

MNA president appears on two broadcasts

MNA President Karen Higgins debated nurse-to-patient ratios with Massachusetts Organization of Nurse Executives (MONE) President Karen Moore on NewsNight, March 30 with host Jim Braude. The debate also appeared on the CNBC talk show “Education Forum,” where she engaged in an hour-long discussion on the nursing crisis.

Patient poll findings generate front page coverage

MNA Executive Director Julie Pinkham was at the podium on March 30 at the Federal Reserve Bank in Boston where she delivered findings of a statewide survey conducted by Opinion Dynamics Corp. relative to patients’ perception of safety. Pinkham’s address was made during a forum on pending legislation to regulate RN-to-patient ratios in Massachusetts hospitals. The poll (key findings of which appear on Page 14 of this issue of The Massachusetts Nurse) indicates that one-quarter of the 200 surveyed former patients and their family members thought their safety was compromised by nurse understaffing. The Boston Herald subsequently ran a page one story on March 31 providing details of the event and results of the poll.

MNA member says hospital sidesteps minimum staffing and overtime agreements; makes headlines

The Telegram & Gazette on April 1 ran a lengthy article based on charges made by Sandy Ellis, a psychiatric nurse at St. Vincent Hospital at Worcester Medical Center and MNA board member, that the hospital is jeopardizing patient safety by not assigning enough nurses to medical-surgical units. Ellis is quoted as saying that despite a union contract that sets minimum staffing rules and prohibits mandatory overtime, the hospital “finds ways to ignore or abuse” these guidelines. Ellis is also attributed with saying that some St. Vincent nurses care for seven or more patients at a time when a patient-to-nurse ratio of 4-1 is the minimum required for safe care.

Union local chair quoted in article on patient safety

Jacqueline Bronnihan, a surgical nurse at UMass Memorial Medical Center in Worcester, where she is also chair of the union local, was quoted in an April 1 article in The Telegram & Gazette as saying hospital officials “are unwilling to turn away patients or divert them to another hospital because it would be a loss of revenue.” The article points to the MNA’s criticism of the Massachusetts Hospital Association’s “Patients First” initiative and the union’s charge that the critical care unit at the hospital often has RNs caring for three or four patients, a violation of state regulations that call for a maximum 2-1 patient-nurse ratio in such units. In the article, Bronnihan calls the alleged violation “a budget issue.”

Anna Jaques RNs come to rescue

Emily Bates and Renee Lundy have established a special serendipitous meeting in an April incident when the two off-duty RNs saved the life of a drowning man.

“It was like divine intervention that we both happened to be there,” according to Bates, a 20-year-staff nurse care nurse at Anna Jaques Hospital in Newburyport, who was preparing to leave Salisbury Beach with her daughter and grandchildren on that warm spring afternoon when she heard cries for help from Heidi Teel of Amesbury, whose boyfriend, Brian Parks, of Groveland was in crisis.

“I had noticed a young man there with his girlfriend and a few other friends,” said Bates. “He dove into the water and apparently was in trouble. His girlfriend went in, grabbed him and pulled him to shore and that’s when I rushed over.”

What the off-duty RN saw was an 18-year-old man, blue and frothing at the mouth.

“He was gone—no pulse, no respiration,” said Bates. “I went over a few months earlier and had been re-certified in cardiopulmonary resuscitation. ‘I started breathing and got nothing and then Renee Lundy came by.’

“It’s amazing that we were both on the beach at the same time in the middle of April,” said Lundy, an obstetrics nurse at Anna Jaques for the past five years. “I came up to Emily almost immediately after she started administering CPR and said ‘I’m a nurse, can I help.’ It was like something out of the movies.”

Bates and Lundy had on occasion passed each other in the hallways of Anna Jaques Hospital, but had never met.

“We were working on this young man, we pieced together that we were both nurses and worked at the same hospital,” said Lundy. “We felt comfortable with each other and just did what we could.”

Doing what they could involved administering eight compressions to Parks before finally receiving a pulse. In the meantime, Bates’ daughter, Nicole Morgan, called 911 and also contacted Parks’ father.

Paramedics arrived at the scene shortly thereafter, and stabilized Parks before transporting him to Anna Jaques Hospital. Parks was subsequently airlifted to Brigham & Women’s Hospital in Boston for treatment of a spinal cord injury.

“I found out this morning that he is moving his fingers and toes, is able to talk and is in stable condition,” Bates told Massachusetts Nurse two days following the April 20 incident. “I’m just so glad to have some good news about him.”

As for the off-duty RN’s serendipitous meeting, both Bates and Lundy feel it was fated. “It’s incredible; as if we were meant to be there,” said Bates. “It was definitely connected, now.”

“We worked on this young man together, prayed for him together and knew we were there at that moment in time for a special reason,” said Lundy. “The most important thing is he is alive and doing all right.”

As for what has also come from this is a new friendship—I’m sure Emily and I will be going to the beach together.”
MNA position statement opposing DPH policy allowing boarding and care of patients in the corridors of inpatient units

The MNA recently issued a position statement addressing its opposition to the unsafe practice of stationing patients in hospital corridors and hallways. The following is the text of its executive summary.

Executive summary

In the strongest possible terms, the Massachusetts Nurses Association opposes its state’s latest policy relative to the policy introduced by the Massachusetts Department of Public Health and promoted by the Massachusetts hospital industry to allow the boarding and care of patients in beds stationed in corridors and hallways outside hospital inpatient units.

All hospitals are licensed by the DPH to provide appropriate nursing and medical care to a specific number of patients, with the understanding that a hospital will only admit those patients it has the resources, staff, equipment and facilities needed to deliver said care.

This policy was established and promulgated in January as a means of dealing with the problem of emergency department overcrowding and ambulance diversion. The MNA believes this policy is not a solution; rather, it creates more problems and raises further issues relative to the safety of patient care. As such, it generates a larger crisis than the one it was designed to resolve.

This policy directs hospitals and nursing staff to engage in practices which are unmistakably dangerous, irresponsible, and unethical, and in many ways, are in direct violation of state and federal laws, HIPPA and JCAHO requirements, and the department’s own regulations. The DPH has created a policy specifically allowing a practice the department used to cite hospitals for violating.

For patients, this policy would promote degraded and substandard care that no one would wish to receive nor should expect to receive in a state that prides itself on having the nation’s oldest public health department and the premier system of hospital care.

Any hospital implementing this policy is committing willful abuse and neglect of its patients. Any nurse who is forced to accept such an assignment is being placed in an environment ripe with violations of the Nurse Practice Act and/or their standards of nursing practice, which ultimately could result in harm to their patients and the potential loss of their license to practice.

Family members whose loved ones receive care in such an environment are advised to seek immediate transfer of the patient to a facility better equipped to provide a safe standard of patient care. By definition of this DPH policy, any patient eligible for care in a corridor must be “stable” and non-emergent, and therefore, would not be harmed by being transferred to another facility to receive appropriate care in a properly appointed and staffed patient room.

Nurses, both in the emergency department and inpatient units are already working to their full capacity and under the current unsafe staffing conditions in hospitals, caring for far too many patients to provide appropriate care. Now we are asking those nurses to be assigned additional patients who must be cared for in an environment (hallways) that is not conducive to the delivery of any standard of appropriate care. In so doing, they not only jeopardize the safety of the new patients in the hallways, but would now be forced to provide their existing patients with substandard care as well.

Unless all surrounding hospitals have no beds available to admit patients, it is clearly safer for patients to be transported to another facility than it is to place them in an environment that puts them and all other patients on that unit at such great risk.

The MNA agrees that ED overcrowding and ambulance diversion presents a longstanding and serious public health crisis that must be addressed, this DPH policy demonstrates a lack of commitment by the DPH to use its regulatory power and oversight to properly protect the health of the residents of the Commonwealth.

This problem has been growing for many years, yet DPH has failed to generate long-term solutions. While the DPH oversaw the closure of hospital beds throughout the state, it has failed to:

- mandate that hospitals take appropriate control of elective admissions or regulate suitable hospital discharge procedures;
- assess the need and plan for added bed capacity;
- require improvement in patient flows or assist in the development of appropriate patient bed capacity;
- investigate the creation of mobile units for disaster use or develop state facilities for emergency or overflow use;
- support the nurse staffing levels widely judged necessary to provide adequate daily staffing for DPH-licensed beds, let alone staffing for patients in corridors.

For its part, the hospital industry has driven the macro policy changes that caused this problem with its push for deregulation of the industry in the early 1990’s and its lust for cut-throat, free market competition and massive consolidation. These actions resulted in the elimination of 30 percent of our available hospital beds. In essence, the industry has created the very bed it wishes to foist into the hallway to accept a patient.

In issuing this statement we call upon the Massachusetts DPH to immediately rescind this policy and, as the largest stakeholder, request an immediate meeting on this issue. We call upon the Massachusetts Hospital Association to refuse to embrace such substandard care and to advise its members to reject this policy. In lieu of these actions, we call upon the Massachusetts Legislature to use its oversight authority to hold emergency hearings on this public health safety threat and intervene as required to protect the public.

For our part, the MNA is advising all registered nurses against accepting any assignment of a patient to a hallway or a corridor of an inpatient unit, and for nurses in emergency departments to accept such an assignment only if necessary staff have been added to properly monitor those patients while they await a proper inpatient bed assignment. Further we intend to educate both the nursing community at large and the patient population about the dangers of this policy and to seek nurse and patient support in advocating for its immediate rejection.

We further encourage the DPH to begin development of both an immediate and long-term plan that genuinely addresses the issue of emergency department overcrowding—a plan that doesn’t give the illusion of stopping diversions and one that doesn’t place patients in greater danger.

The official MNA position statement includes extensive information on how this policy violates basic tenets of patient care, nursing practice standards, HIPPA regulations, JCAHO requirements, the Nurse Practice Act and Board of Registration in Nursing regulations. It also breaches patient privacy rights, infection control standards and nursing ethics.

To view the entire position statement, visit the MNA Web site at www.massnurses.org.

MNA members explain staffing crisis on TV4

“We’re at our worst nightmare; we never want to live with the fact that we hurt somebody,” said Higgins, noting that hospitals “have changed” driven by managed care.

“We have much sicker patients that need a lot more care and we are taking care of twice the number we did before,” said Higgins, as other panelists addressed the stresses innate to being a nurse within a system where minimum safe RN staffing ratios are not yet mandated.

“I have a daughter in college who wanted to go into nursing but told me ‘I can’t do it, mom—you work too hard,’” said Kelly-Williams. “But we wouldn’t do it unless we really and truly loved it.”

Discussed was the perception of a shortage of nurses, one that Higgins challenged, saying “it’s about a shortage of nurses willing to work under the conditions we’re working under.”

Ellis said there are “plenty of nurses with licenses in Massachusetts but so many of them work for pharmaeutical companies or in research or own flower shops.”

Ellis maintained that “bedside nurses would come back if our safe nurse to patient legislation is passed,” in reference to MNA’s patient safety/safe RN staffing bill (H.2663) on the 2005-2006 legislative agenda.

“This legislation would require and mandate the number of patients that a nurse would be taking care of,” said Cook. “There shouldn’t have to be a law passed, but that’s what we have to do in order to ensure the safety of our patients.”

Asked by Hughes if patients are at risk “in the meantime” all panelists adamantly said “no.”

“We’ve been saying that the more patients we have, the more patients are paying for it,” said Higgins. “Patients are dying; they’re getting sicker; the infection rate is increasing; injuries are happening. Management asks ‘where’s the data?’ In the last five years there have been more mistakes.”

That may be the most telling data of all.
Nursing Against the Odds: A definitive account of the world’s nursing crisis

MNA goes one-on-one with award winning health care journalist Suzanne Gordon

Author Suzanne Gordon raises a series of compelling questions in her recently released book Nursing Against the Odds: How Health Care Cost Cutting, Media Stereotypes, and Medical Habits Undermine Nurses and Patient Care. What has the recent restructuring of the profession done to our understanding of how these decisions affect nurses and patients? What possible future for patient care in the future? What elements must be in place to promote better quality care? Gordon, the author of Life Support: Three Nurses on the Front Lines and the co-author of From Silence to Voice: What Nurses Know and Must Communicate to the Public recently sat down with the editorial board at MNA to discuss her latest work and the questions it generates.

This is the third major book you have published on nurses, particularly front-line nurses. As someone who is not a nurse herself, what keeps bringing you back to this profession and the issues it is now confronting?

Nurses are often surprised that a non-nurse spends so much time writing about nurses, by asking how you do it—“is fascinating. I have deep admiration for nursing work and I’m interested in how social institutions function. For me, why hospitals and health care systems make it so hard for nurses to properly do their job caring for patients is an important social policy question. I’m also very concerned about the future of nursing from a personal, even selfish, point of view. I think of myself as an SP, or PP — a sometime patient or potential patient. I worry about what will happen to me or my loved ones and friends, if, because nursing is not a long-term satisfying career, three won’t be enough nurses to take care of us. Like other members of the public, I want to know we can count on having well educated, experienced, and well treated nurses to take care of us when we are sick, old, infirm, or dying.

You are very clear in your introduction that this is a book about bedside nurses and their issues. Why the distinction?

I define the bedside pretty broadly. I am concerned about nurses who give direct care to the sick and vulnerable who work in hospitals, rehab facilities, in the home, in clinics, in schools, in psych facilities, etc., or who work as clinical specialists. Nurses in other areas of nursing do important things and have significant problems, but I don’t think we confront a crisis because we lack nurses who are CEOs or policy makers or business owners. There’s a shortage of RNs working in direct care because, for very clear and understandable reasons. Fewer people are willing to work under the current working conditions and cannot survive financially the way they are.

The first half of your book details problems with nurse doctor relationships. Can you explain why you spent so much time on this subject?

While excellent in some areas, the relationship between medicine and nursing and doctors and nurses, is, from a system point of view, pretty terrible. I think that many doctors fail to understand what nurses do and what their function is. Some treat nurses pretty badly. As an organized discipline, medicine tends to exert its authority over nursing in undermining the possibility of genuine teamwork. Too few doctors understand what nurses do and what function they play in health care. This has a significant impact on the self-esteem of nursing and nurses, and has an adverse impact on patient care. Dysfunctional doctor-nurse relationships can even kill patients.

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I tried to explain why she became more and more agitated. No one had time to help us and they left us pretty much alone. I went off to find a nurse or a doctor. When I came back to her cubic, I found a nurse wiping blood from my mother’s face. I told the doctor my mother had pulled out her IV. Although she was less than five feet tall, she tried to get off the high gurney and almost fell. When I asked what on earth she thought she was doing, she said calmly, “Well, they want me to leave, so I’m leaving.” Even with a mind clouded with senile dementia, she none-the-less understood that the hospital system and everyone in it — nurses included — was not hospitable to patients like her and that self-help was needed. From this as well as many other conversations with patients, I learned what happens when nurses don’t have time to rescue patients.

You also highlight something that has been yet to be widely covered, which is the impact overwork and stress from understaffing can have on the nurse’s ability to maintain empathy. Can you talk a little bit about those findings?

I think the incident I just described says a great deal. The nurses trying to care for my mother had so little time and energy left over that they simply didn’t have the physiological capacity for empathy — to see things from the patient’s point of view. Because of our stereotypes of the nurse as saint or angel or mercy, patients, policy makers and health care administrators — and even some nurses — too often assume RNs can turn empathy on and off like a faucet. What I explore in the book is how chronic workplace stress can make it physiologically difficult — if not impossible — for people to produce empathic responses to the sick and vulnerable. The issue isn’t simply that nurses don’t have time to listen to patients’ fears and concerns. Even if they have a few extra minutes, chronic stress changes their brain chemistry environment and they have trouble integrating information. They might not even be thinking about it. When you spend time running from crisis to crisis, there are so many hormones coursing through your body, that you just can’t mobilize empathetic attention. It’s too difficult, if not impossible. So when we ask nurses to be empathic under current conditions, we’re asking the impossible.

The hottest debate in nursing right now is the debate over working conditions and specifically RN to patient ratios. You have covered what is happening in California and Victoria Australia. What do think about legislation to regulate ratios and do you have specific recommendations for your research of ratios in other places?

I think some form of legislated ratios is essential. The nursing workload must be controlled if patients are to get the kind of care they need. In my research I spent a lot of time talking to nurse executives and nurse managers and they have told me they are not pleased at the pressures they are under to increase patient loads. But they do value the professional individual power to resist and have not been able to muster the collective power to mount a successful fight against cost-cutting. They are caught somewhere between an increasing number of hospital administrators on the one end, and nurses and patients on the other. The only way to deal with this is through safe staffing legislation. To legislate the maximum number of patients assigned to a nurse does not mean that you have legislated the maximum number of nurses assigned to a patient. It’s really tragic, because this issue has been so badly misconstrued in the US. Over the past five years, I’ve spent a lot of time in the state of Victoria in Australia. The Victorian branch of the Australian Nursing Federation fought for staffing ratios — which were implemented in 2000. So we have no lift rules. This brought about 5,000 inactive RNs back into the system. Although ratios don’t solve all the problems nurses have, nurses in Victoria love them. What is more, nurse managers and nurse executives in the state of Victoria favor ratios because it protects their budgets from cost-cutting pressures and they actually have control over their workforce.

You also provide important information on what nurses need to do to improve their image in the public and better communicate their issues. What advice would you give our readers in this regard?

More nurses need to talk about their work. They have to stop mobilizing archaic images of hearts, and saints and angels and gauzy images of sweet women caring. I feel very strongly that nurses have to stop focusing on what Siobhan Nelson and I call the “virtue script” of nursing — a script that focuses on compassion and kindness as almost hormonal, attributes. They need to utilize the new research that explains how nurses rescue patients from the risks and consequences of illness and its treatment. When nurses talk about caring they need to explain that caring is a skill that nurses master in their education and throughout the job experience. Images of nurses as holistic and humanistic will not sway budget cutters. Nurses must explain how mobilizing a holistic and humanistic approach reduces suffering, enhances patient outcomes and actually saves money. Nurses have to convince us — and the MNA has been a leader in this area — that nurses are not a cost center. In hospitals, nurses help to generate revenue because you can’t admit patients to a nurse-less hospital and nurses save money by preventing catastrophic complications that are very costly. I encourage each nurse to tell stories that illustrate very concretely why a nurse’s routine daily activities make a difference to patients.

Meet the author on June 2

Suzanne Gordon will hold a book signing, reading and discussion from 7–8:30 p.m. on June 2 at Porter Square Books, 25 White Street, Cambridge, at the Porter Square T stop for her new book. Wine and cheese will be served.
Health and Safety at Work
Learn about OSHA requirements for health and safety in your hospital
OSHA 10-hour General Industry Outreach Training with a focus on the healthcare industry
Program offered in two parts at Region 3 Headquarters
449 Route 130, Suite 6, Sandwich
8:30 a.m. to 3:30 p.m.
Part 1: Wednesday, May 25
Part 2: Wednesday, June 15
No charge to MNA members
Fee for all others: $45 for the OSHA Standards Textbook
OSHA Authorized Trainer – Evie Bain
MNA Health and Safety Program Coordinator
Contact Hours provided by the Greater Boston Chapter of the American Association of Occupational Health Nurses
6.0 contact hours for each part – Total 12.0
OSHA Certificate to those who attend parts 1 and 2
MNA members: For information and to register call Susan Clish at 781-821-4625 x 723 or e-mail at sclish@mnarn.org
GBAONH members: for information and to register call Terry Donahue at 781-784-5158 or e-mail at tadhfd@comcast.net
Chemical Sensitivity: Scents may trigger responses in those with chemical sensitivities. Men and women are asked to avoid wearing scented personal products when attending this meeting/program.
Parking: There is ample free parking on all sides of the building.

Early Registration Suggested
Class Limited To 35 Participants

So you think it’s safe at work? Notes from the Congress on Health and Safety

Health effects of fragrances: a Q & A

By Peggy Wolff, M.S., R.N.C.S

Do you know anyone who is bothered by fragrances? You probably do because more than 20 percent of our population now experiences adverse health effects when exposed to fragrances.

Why are fragrances such a problem? For two reasons. First, 95 percent of fragrances are synthetic compounds made from petroleum products, most of which have never been tested for human toxicity. Second, fragrances are made to be volatile, so the chemicals in these fragrances stay in the air and are readily inhaled or absorbed through the skin.

Are “natural” scents a problem? People who don’t feel well around synthetic fragrances generally don’t feel well around some essential “natural” oils such as citron, galbanum, and, in particular, patchouli oil.

What health effects can occur from fragrances? Minor effects include eye, nose and throat irritation, dry cracking skin, rashes and headaches. More serious health effects include vertigo, fatigue, nausea and vomiting, kidney and liver damage, blood pressure changes, central and peripheral nervous system changes, difficulty breathing and, in rare cases, death.

Who is particularly bothered by fragrances? People with allergies, asthma, compromised or immature immune systems and those who are chemically sensitive are most susceptible. Be aware that fragrances are a “barrier to access” for some health conditions under the Americans with Disabilities Act of 1992. If you avoid wearing perfume/cologne, are you free of fragrances? Probably not. Fragrances are in almost all personal care and laundry products that most of us commonly use.

Did you know?
• Fragrances are one of today’s major sources of indoor air pollution.
• Fragrances, although under FDA jurisdiction, are one of the least regulated substances.
• Some fragrances contain chemicals designated as hazardous waste disposal chemicals such as methyl chloride, toluene and ethanol.
• Some municipalities like Shutesbury, Mass., and Halifax, Nova Scotia, have banned the use of fragrances.
• Secondhand smells are as much a problem as secondhand smoke.
• Some products labeled “unscented” may contain toxic “masking” fragrances.

What can you do?
• Avoid the use of synthetic fragrances and selected essential oils when at work or in public places.
• Request fragrance-free classes, meetings, conferences, etc.
• Educate other health care professionals, clients and the general public about the adverse health effects of fragrances.
• If a particular fragrance is bothersome to you, speak up.
• Subscribe to magazines that refrain from using fragrance inserts.
• Write to the Office of Cosmetics and Colors, FDA, Washington, D.C. 20204, about any problems with fragrances and scented products.

You don’t have to go to a health food store to buy fragrance-free products. Local drug stores and grocery stores carry fragrance-free products. Read the labels; fragrances are usually the last ingredient listed.


Peggy Wolff, M.S., R.N.C.S. is the Director of Healthy People & Healthy Places, which provides advocacy, counseling, and educational services related to complex health conditions, including environmental health issues. She can be reached at 413-253-2646 or hhpwolf@aol.com.

In collaboration with Mass. DPH
MNA offering bioterrorism preparedness modular presentation components

Health & Homeland Alert Network

As a secure application interfaced with a wide range of devices (e.g. pager, fax, phone, email, wireless), the Health & Homeland Alert Network will establish the infrastructure necessary for continuous secure communication and information sharing in support of aspects of bio-terrorism preparedness including, but not limited to, response planning, educational services, disease surveillance, laboratory reporting and epidemiological investigation. The core functionality of the alert network will provide a secure means to utilize the following:
• A role-based user directory containing the contact information of all appropriate commonwealth responders
• Confirm receipt of user-specific rapid communication for emergency situations (can alert phones, fax, email and pager)
• Online news postings for low-priority information dissemination
• Online training documentation and schedules to ease administrative burden associated with any existing and/or future educational services

The specific objectives for this “HHAN Alert only” training are:
• Access the HHAN from any Internet-connected computer
• Set up participants’ individual profiles to receive alerts via the method(s) they choose
• Use the role directory to find contact information for any user on the system
• Receive and confirm alerts of varying importance
• Respond to alerts via phone, e-mail, fax, etc.

Presentation credit 1.5 CMEs and 1.8 nursing contact hours.

Rash Surveillance

The presentation will include an overview of macular, papular, vesicular and pustular rashes, as well as the adjectives frequently used to describe such rashes. The focus of the presentation is being able to differentiate chicken pox from smallpox and other similar types of rashes. Finally, the presentation will review the school nurse’s role, responsibility and method of reporting the occurrence of chicken pox in the school setting.

The specific objectives for rash surveillance presentation are:
• Describe various rash presentations: macular, papular, vesicular and pustular
• Identify rash epidemiology of smallpox vs. varicella
• Understand the various reporting mechanisms for rash surveillance
• Complete varicella reporting form, providing the essential information to LBOR

Presentation credit 1.5 CMEs and 1.8 nursing contact hours.

Behavioral Health Disaster Response

The presentation on Behavioral Health Disaster Response will include a general overview of critical incidents and emergency events. The presentation will include a definition of behavioral health and a description of how behavioral health interventions can both prevent and mitigate certain consequences of disasters and other emergencies. The presentation will identify how emergency events affect individuals, families and communities and how disaster stress, a normal response to abnormal events, is usually manifested. Long-term behavioral health effects of disasters, such as Post Traumatic Stress Disorder, will be explained and discussed in the context of both prevention and intervention.

The specific objectives for the behavioral health disaster presentation are:
• Define “Critical Incident” and identify the behavioral health issues of both natural and human-caused emergency events
• Understand how emergency events affect the behavioral health of individuals, families and communities
• Describe the symptoms of and interventions related to disaster stress (the normal response to an abnormal event) and long-term issues such as Post Traumatic Stress Disorder

Presentation credit 1.5 CMEs and 1.8 nursing contact hours.

If you are interested in having one or more of these programs brought to your facility, contact Chris Pontus at 1-717-830-5754 or email cpontus@mnarn.org.
Massachusetts patients say nurse understaffing undermines quality care

More than one-quarter of Massachusetts hospital patients and their families say the quality of patient care was at least somewhat compromised during recent hospitalizations by nurse understaffing, and nearly one-third thought the quality of care was compromised, according to a statewide survey conducted by Opinion Dynamics Corporation (ODC) of Cambridge. The new data was released March 30 at the Federal Reserve Bank in Boston at a forum on pending legislation to regulate RN-to-patient ratios in Massachusetts hospitals.

The poll revealed that 28 percent of those who spent one or more nights in the hospital say that their safety—or their family member’s safety—was compromised. More than 1 in 10 (12 percent) say patient safety was extremely or very compromised. Based on the total number of hospital stays in the commonwealth, this translates to approximately 233,000 Massachusetts patients annually who feel their safety is compromised by a lack of available nurses.

Nearly one-third (31 percent) of past patients and their families also report that the quality of patient care was at least somewhat compromised by a lack of available nurses. They said that important elements of routine care were not delivered in a timely fashion—this includes assistance when complications arose, delivery of medications, and information when patients had questions about their illness.

Behind the numbers are patients who suffered pain or indignities unnecessarily:

- A Merrimack Valley man with heart problems who has been in and out of hospitals for five years because of heart attacks and heart operations.
- His wife says she has seen the quality of his nursing care decline with each admission, with nurse understaffing more and more apparent. She also told researchers that while emergency room and ICU nursing care for her husband was excellent, there is a noticeable deterioration in staffing when he is moved into standard units.
- A two-week-old infant, being treated in a teaching hospital for bronchitis, nearly did not receive his treatment because the respiratory therapist was sent to the wrong crib. He was never bathed during the course of his stay, leading his mom to say she was “appalled” by the lack of adequate nursing care.
- A 76-year-old woman from a suburb southwest of Boston who was hospitalized for four weeks because of a spinal fracture and who was left in pain on a bed pan for more than thirty-five minutes because nurses could not tend to her due to other patients’ needs.
- A 40-year-old woman undergoing bypass surgery at a Boston teaching hospital had her throat injured when a harried nurse removed the patient’s ventilator tube. It took several days, her mother said, before the damage was discovered and treated. The mother blames the working conditions—too many patients—the nurses had to care for.

Almost universal acknowledgement from patients—even from those with no complaints about their treatment—that bedside nurses are overworked and overstressed.

“These findings paint an alarming picture,” said John Gorman, ODC’s president. “A significant number of patients and their families lack confidence about Massachusetts hospitals—and that was noted that prides itself on being at the forefront of medical care.”

“I don’t know how many times we need to share information like this before the messages sinks in with legislators: patients are suffering because of RN understaffing,” said MNA President Karen Higgins, RN. “Nursing is the key to quality hospital care. An RN

See Understaffing, Page 15

Scholarship funding available through the Massachusetts Nurses Foundation

Printable applications are available at www.massnurses.org. Application deadline is June 1, 2005.

For further information or to request an application, call the MNF Voice Mail at 761-830-5745 and leave your name (please spell), address and name of the scholarship application you would like mailed to you.

Janet Dunphy Scholarship

Funded by a scholarship established by Regional Council 5, scholarships are being offered to an active member in Regional Council 5 as follows:

- Five $2,000 scholarships to those pursuing a BSN. Second preference to those seeking advanced degrees in public health policy or labor relations.
- Three $2,000 scholarships to those pursuing a MSN. Second preference to those seeking advanced degrees in public health policy or labor relations.
- Two $2,000 scholarships to those pursuing a PhD in Nursing. Second preference to those seeking advanced degrees in public health policy or labor relations at any level.

Regional Council 5

Funded by Regional Council 5, family scholarships:

- Five $2,000 scholarships to a child of a member of Regional Council 5 who is below the age of 25 and pursuing a BSN, or nursing degree in an accredited AD program in nursing.
- One $2,000 scholarship to a spouse of a Regional Council 5 member pursuing a BSN or nursing degree in an accredited AD program in nursing. Second preference will be given to those pursuing a degree in public health policy, health care professional tracts or labor relations.
- One $1,500 scholarship to a child of a member of Regional Council 5 who is below the age of 25 and pursuing higher education at any level in any course of study in an accredited program.
- One $500 scholarship is being awarded to a member of Regional Council 5 who is pursuing a BSN. Second preference will be given to students living in or working in the Worcester area first, and then to other areas of MNA.

Regional Council 2

Funded by Regional Council 2, scholarships will be awarded as follows:

- One $1,000 scholarship to those pursuing a BSN, MSN or Doctoral Degree.
- Two $1,000 scholarships to a child of a member of Regional Council 2 pursuing a nursing degree.
- One $1,000 scholarship to a family member of Regional Council 2 for continued education in nursing.

Regional Council 4

Funded by Regional Council 4, scholarships will be awarded as follows:

- One $1,500 scholarship to a member of Region 1 member, or a student sponsored by a Region 1 member pursuing a degree in nursing.
- One $1,000 scholarship to a member of Regional Council 3 pursuing an associate’s degree in Nursing.
- Two $1,000 scholarships for an RN or health care professional, member of MNA, attending a baccalaureate or masters program in nursing, labor relations or related field.

Kate Maker Scholarship

This scholarship was established to honor the memory of Kate Maker, RN, a great leader and powerful activist. Kate’s primary focus as an activist was with the Massachusetts Nurses Association. Kate was a long-time member of the MNA Board of Directors, and she served two terms as the chairperson of her bargaining unit at UMass Memorial Health Care’s University Campus in Worcester. Kate participated in pickets and strikes for nurses at several Worcester area hospitals and particularly effective when it came to explaining the connections between safe-RN-staffing ratios and their immediate impact on patient safety.

The scholarship will be awarded to a student (entry level or practicing RN) pursuing an Associates Degree or Bachelor’s Degree in nursing. Preference will be given to students living in or working in the Worcester area, and then to other areas of MNA Regional Council II. If the applicant is a practicing RN pursuing a Bachelor’s Degree, she/he must be an MNA member. In the event that no applicants meet the geographic criteria listed above, the scholarship will be awarded to a deserving candidate that meets all of the other criteria determined by the MNF scholarship committee.
Donations needed for MNF Auction!

We Need Your Help

The Massachusetts Nurses Foundation is preparing for its 22nd Annual Silent & Live Auction to be held at the MNA 2005 Convention. Donations are needed to make this fundraising event a big success. Your tax-deductible donation helps the Foundation raise funds to support nursing scholarships & research.

- Valuable Personal Items
- Gift Certificates
- Works of Art
- Craft Items
- Memorabilia & Collectibles
- Vacation Packages

Contact the MNF at 781-830-5745 to obtain an auction donor form or mail or deliver your donation to the Mass. Nurses Foundation, 340 Turnpike Street, Canton, MA 02021.

Join MNA for an exciting trip to the Italian Riviera!

Reserve Early • Space is Limited

Nov. 12–20, 2005: Italian Riviera, $1569*

Join this wonderful nine-day, seven-night tour to the beautiful Province of Liguria, which is nestled along the Italian Riviera (north of Florence and south of Milan). You will enjoy a seven-night stay in a first-class hotel overlooking the azure Gulf of Spezia. The tour includes an extensive daily sightseeing program with three meals every day. During this vacation we will visit Portovenere, Genoa, Portofino, Cinque Terre, Carrara, Pisa, Sarzana, Pontremoli, Lerici, San Terenzo and Vernazza. The area’s mild climate permits visits to these places all year long and our itinerary features short daily excursions throughout the magnificent countryside and along the beautiful coastal region. Don’t miss this grand tour of the picturesque Riviera region.

To receive more information and a flyer on these great vacations, contact Carol Mailia at 781-830-5744 or via e-mail at cmailia@mnarn.org

* Prices listed are per person, double occupancy based on check purchase. Credit card purchase is $30 more. Prices include air fare, hotel, transfers, tours and all meals. Applicable departure taxes are not included in the listed prices above.
Taking risks: Does your employer provide enough liability insurance coverage?

“The need for nurses to carry their own individual professional liability insurance policy is imperatival,” according to Dorothy McCabe RN, MS, M.Ed., Director of Nursing and Career Services for the Massachusetts Nurses Association (MNA). Since 1996, MNA has endorsed the purchase of personal professional liability insurance policy administered through Nurses Service Organization (NSO), and underwritten by American Casualty Company of Reading, Pa., a CNA company.

Hospitals and clinics have been downsizing and right sizing, forcing a reduction to their nursing staff, potentially leaving a nurse practicing in a dangerous environment with too many patients and increased responsibilities. Further, some hospitals have been forced to close their doors. Will a former employer, if they still exist, defend you as vigorously if you are working somewhere else?

Ask yourself if you should purchase your own policy rather than depending on your employer. Unlike employer’s policies, the policy available through NSO, which is endorsed to nurses and practitioners nationwide, will give you peace of mind because of its 24/7 protection – that’s protection for you, on or off the job.

Whether you are relying on your employer’s coverage or have no coverage at all, you should ask yourself some very important questions, said McCabe, an NSO policyholder.

Do I have enough coverage?

All professional liability insurance policies include limits of liability that consist of an amount of coverage per claim, and a total amount of coverage (or aggregate), for all incidents during a specific time period. But remember, if your employer’s policy covers you, then it likely covers other employees as well. This means that other defendants may share your liability limits and the money available to pay malpractice awards may be diluted if they are also named in a lawsuit. If you are named in a malpractice lawsuit and the total costs surpass the limits of your employer’s policy, you may be required to pay the difference out-of-pocket. With the policy available through NSO, you are covered for up to $1,000,000 each claim and up to $6,000,000 aggregate, and the policy is your own.

What expenses are covered?

If you’re a defendant in a lawsuit, you may face many unexpected expenses. If your employer’s insurance only covers liability settlements, defending yourself could cost thousands of dollars in lost wages and other out-of-pocket expenses – even if you win. The policy offered by NSO covers you beyond the malpractice awards because the policy includes additional coverages, like legal defense, defense representation for covered claims and additional coverages, explained below, at no extra cost.

How are defense attorney costs managed?

While most, if not all, individual malpractice insurance policies will provide you with an attorney to defend you against allegations of malpractice, some policies may deduct these defense costs from your limit of liability. This practice will obviously leave you with less money to pay for any judgment against you. If you file a claim with NSO, we will forward all necessary information to CNA. Subsequently, CNA will assign your case to a claims consultant, promptly contact you to discuss the issues, appoint defense counsel to represent you personally, when necessary, supervise counsel’s representation, and keep you informed every step of the way. Legal fees will be paid for covered claims, in addition to your limits of liability regardless of whether you win or lose in a lawsuit, or if it ever goes to trial. (As the program administrator, NSO manages all processing of the initial incident or claim from its customers. NSO also handles the marketing and customer service for the nurses professional liability insurance program. CNA, being the underwriter of the policy, also known as the insurance carrier, assumes the liability when a claim is filed.)

What if I am deposed?

In almost all cases, you will be court ordered to attend a deposition prior to the actual malpractice trial. A deposition, also known as “discovery,” is a court sanctioned hearing in which all parties participate in a formal question-and-answer session to find out information relevant to the lawsuit. If you have been named in a covered lawsuit as a defendant, CNA will ensure that you are prepared for the discovery phase of the suit.

There may be a situation where you are not named in a lawsuit but you are deposed for a suit against your employer or a co-worker. If you are required to appear at a deposition that arises out of professional services, the policy available through NSO will reimburse you up to $5,000 aggregate, up to $2,500 per deposition for attorney’s fees.

What about lost wages?

If sued or deposed, you will be attending both pre-trial proceedings and your actual case in court. This could involve you taking time off from work and traveling to wherever your case is being adjudicated. The policy offered through NSO reimburses you up to $10,000 aggregate for lost wages and covered expenses incurred when you attend a required trial, hearing or proceeding as a defendant in a covered claim.

Is my license protected?

Because any medically related complaints that nurses could face is the suspension or withdrawal of their license. Without your license, you lose your ability to work, which can be devastating. Because any medically related complaints must be investigated by your state licensing board, coverage that will provide you with a means to secure experienced legal representation and reimbursement of out-of-pocket expenses is a vital benefit to have. Employers rarely provide license protection.

With the coverage available through NSO, license protection coverage is included. This coverage reimburses you up to $25,000 aggregate, up to $10,000 per proceeding for your defense of disciplinary charges and other covered expenses arising out of a covered disciplinary action against your license.

What else is covered?

In addition to the individual malpractice benefits, the professional liability policy offered through Nurses Service Organization provides additional coverage extensions you would not likely see through your employer’s coverage. Again, this is at no extra cost. What are these additional benefits?

• Personal liability protection. You’re covered, up to $1 million aggregate (depending on the limits you choose), for liability damages for covered claims resulting from incidents at your residence that are unrelated to your work.

• Medical payments. Pays up to $5,000 aggregate up to $2,000 per person for reimbursement of medical expenses to others injured at your residence or business premises.

• Personal injury protection. Protects you, up to the applicable limits of liability, against covered claims arising from charges of privacy violation, slander, libel, assault and battery, and other alleged personal injuries committed in the conduct of your professional services.

• Damage to property of others. Pays up to $10,000 aggregate, up to $500 per incident for damage caused accidentally by you to the property of others at your residence or workplace.

• Assault coverage. Covers your medical expenses if you are injured in an assault related to your property up to $25,000 aggregate, up to $10,000 per incident if you are assaulted at work or while commuting to and from your workplace. (Assault coverage is not available in Texas)

• First Aid Benefit. Reimburses you up to $2,500 aggregate for expenses you incur in rendering first aid to others. Not all malpractice policies are created equal. Your employer’s policy may not cover you for all things related to your job, and certainly may provide no coverage for incidents that occur away from work. If you are currently covered by another policy, compare your benefits with those listed above to see what’s missing. You may be surprised how policies differ from each other.

The most compelling reason for protecting yourself with your own individual professional liability insurance policy is the peace of mind that comes with knowing your legal interests will be served if you are ever sued. For more information call 1-800-247-1500 or visit www.nso.com/massnurse.

Honor your peers with a nomination for 2005 MNA awards

One of the greatest honors one can achieve is the recognition of one’s peers. In this fast-changing health care system in which nurses strive daily to carry out their duties to their patients, there is very little time for them to acknowledge their own professional accomplishments and those of their peers.

The MNA awards, established by the membership with the approval of the MNA Board of Directors, offer all members an opportunity to recognize nurses who, by their commitment and outstanding achievements, have honored us all. These are often ordinary nurses and other individuals who accomplish extraordinary things and who challenge us all to achieve excellence.

Elaine Cooney Labor Relations Award: Recognizes a Labor Relations Program member who has made a significant contribution to professional, economic and general welfare of nursing.

Judith Shindul Rothschild Leadership Award: Recognizes a member and nurse leader who speaks with a strong voice for the nursing community.

MNA Advocate for Nursing Award: Recognizes the contributions of an individual—who is not a nurse—to nurses and the nursing profession.

MNA Human Needs Service Award: Recognizes an individual who has performed services based on human needs with respect for dignity, unrestricted by consideration of national, race, creed, color or status.

MNA Image of the Professional Nurse Award: Recognizes a member who demonstrates outstanding leadership in enhancing the image of the professional nurse in the community.

MNA Nursing Education Award: Recognizes a nurse educator who has made significant contributions to professional nursing education, continuing education or staff development.

MNA Excellence in Nursing Practice Award: Recognizes a member who is a role model by contributing innovative, progressive ideas that serve to improve and enhance clinical nursing practice, including precepting students or new staff nurses.

MNA Research Award: Recognizes a member or group of members who have effectively conducted or utilized research in their practices or who have provided exemplary leadership to assist others in nursing research.

Kathryn McGinn Cutler Advocate for Health & Safety Award: This award recognizes an individual or group of members who have effectively conducted or utilized research in their practices or who have provided exemplary leadership to assist others in nursing research.

MNA Legislator of the Year Award: This award recognizes a deserving freshman state legislator or municipal official who has clearly demonstrated exceptional contributions to nursing and health care.

Frank M. Hynes Award: This award recognizes a deserving freshrn state legislator or municipal official who has clearly demonstrated exceptional contributions to nursing and health care.

For detailed information on selection criteria and to receive a nomination packet, call Liz Chmielski, MNA Department of Nursing, 781-830-5719 or toll free, 800-882-2056, x719. The nomination deadline is June 15, 2005.
**Consent to Serve for the MNA 2005 Election**

I am interested in active participation in the Massachusetts Nurses Association.

**MNA General Election**

- President, General* (1 for 2 years)
- Secretary, General (1 for 2 years)
- Director, Labor* (5 for two years) [1 per Region]
- Director At-Large, General (3 for 2 years)
- Director At-Large, Labor (4 for 2 years)
- Labor Program Member* (1 for 2 years)
- Nominations Committee, (5 for 2 years) [1 per region]
- Bylaws Committee (5 for 2 years) [1 per region]
- Congress on Nursing Practice (6 for 2 years)
- Congress on Health Policy (6 for 2 years)
- Congress on Health & Safety (6 for 2 years)
- Center for Nursing Ethics & Human Rights (2 for 2 years)

*General means an MNA member in good standing and does not have to be a member of the labor program. Labor means an MNA member in good standing who is also a labor program member. Labor Program Member means a non-RN health care professional who is a member in good standing of the labor program.

Please type or print — Do not abbreviate

**Name & credentials**

(as you wish them to appear in candidate biography)

- Work Title ____________________________
- Employer ____________________________

**MNA Membership Number ____________________________ MNA Region ____________________________

**Address ____________________________

- Cty ____________________________ State ____________ Zip ____________

**Home Phone ____________________________ Work Phone ____________________________

**Educational Preparation**

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<th>School</th>
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**Present Offices/Association Activities (Committee, Congress, Regional Council, Unit, etc.)**

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<th>MNA Offices</th>
<th>Regional Council Offices</th>
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**Past Offices/Association Activities (Committee, Congress, Regional Council, Unit, etc.) Past 5 years only.**

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<th>MNA Offices</th>
<th>Regional Council Offices</th>
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Candidates may submit a typed statement not to exceed 250 words. Briefly state your personal views on nursing, health care, and current issues, including, if elected, what your major contribution(s) would be to the MNA and in particular to the position which you seek. This statement will be used in the candidate biography and published in the Massachusetts Nurse. Statements, if used, must be submitted with this consent-to-serve form.

**Signature of Member** ____________________________

**Signature of Nominator (leave blank if self-nomination)** ____________________________

**Postmarked Deadline:** Preliminary Ballot: March 31, 2005  
Final Ballot: June 15, 2005

**Return To:** Nominations and Elections Committee  
Massachusetts Nurses Association  
340 Turnpike Street, Canton, MA 02021

- Hand delivery of material must be to the MNA staff person for Nominations and Elections Committee only.
- Expect a letter of acknowledgment (call by June 1 if none is received)
- Retain a copy of this form for your records.
- Form also available on MNA Web site: www.massnurses.org

**MNA 2005 preliminary ballot**

**President, General**  
1 for 2 years  
Beth DeWees Piknick (Region 3)

**Secretary, General**  
1 for 2 years  
No candidate

**Director, Labor**  
5 for 2 years (one per Region)  
Region 1  
No candidate  
Region 2  
No candidate  
Region 3  
No candidate  
Region 4  
No candidate  
Region 5  
No candidate

**Director At-Large, General**  
3 for 2 years  
No candidate

**Director At-Large, Labor**  
3 for 2 years  
Barbara Norton, RN (Region 5)

**Labor Program Member**  
1 for 2 years  
Beth Gray-Nix OTR/L (Region 5)

**Nominations Committee**  
5 for 2 years (one per Region)  
Region 1  
No candidate  
Region 2  
No candidate  
Region 3  
No candidate  
Region 4  
No candidate  
Region 5  
No candidate

**Bylaws Committee**  
(5 for 2 years) (one per Region)  
Region 1  
No candidate  
Region 2  
No candidate  
Region 3  
No candidate  
Region 4  
No candidate  
Region 5  
No candidate

**Congress on Nursing Practice**  
(6 for 2 years)  
No candidate

**Congress on Health Policy**  
(6 for 2 years)  
No candidate

**Congress on Health and Safety**  
(6 for 2 years)  
No candidate

**Center for Nursing Ethics & Human Rights**  
(2 for 2 years)  
Lolita Roland, RN, BSN  
*General means an MNA member in good standing and does not have to be a member of the labor program. Labor means an MNA member in good standing who is also a labor program member. Labor Program Member means a non-RN healthcare professional who is a member in good standing of the labor program.*
## MNA Continuing Education Courses

Your source for career training and advancement

### Cardiac and Pulmonary Emergencies

| Description | This program is designed for registered nurses in acute, sub-acute and long-term care settings to learn the clinical management of cardiac and respiratory emergencies. Clinical management of chest pain, brief EKG interpretation and ABG interpretation will be covered. Clinical management of respiratory distress will also be discussed. |
| Speaker | Carol Mallia, RN, MSN |
| Date | June 7, 2005 |
| Time | 5–9 p.m. (light supper provided) |
| Place | MNA Headquarters, Canton |
| Fee | MNA members $45; all others $65 |
| Contact Hours* | 3.6 |
| MNA Contact | Theresa Yannetty, 781-830-5727 or 800-882-2056, x727 |

### Cardiac and Pulmonary Pharmacology

| Description | This program will provide nurses from all clinical practice settings with a tool kit of information to minimize liability in nursing practice situations. The elements of negligence and how nurses are accountable through regulations, scope of practice and standards of care will be discussed. Oral pharmaceutical agents and a comprehensive update on insulin therapy will be presented. The nursing management of the newly diagnosed diabetic patient, both complicated and not, will be explored. Nursing management of the diabetic patient in the pre/post operative, ambulatory care, home care and school setting will be discussed. |
| Speaker | Carol Mallia RN, MSN |
| Date | June 21, 2005 |
| Time | 5–9 p.m. (light supper provided) |
| Place | MNA Headquarters, Canton |
| Fee | MNA Members $125; all others $150 |
| Contact Hours* | 7.2 |
| MNA Contact | Liz Chmielinski, 781-830-5719 or 800-882-2056, x719 |

### Basic Dysrhythmia Interpretation

| Description | This program will provide nurses in acute, sub acute and long-term care settings to learn cardiac monitoring and dysrhythmia interpretation. Implications and clinical management of cardiac dysrhythmias will also be discussed. Course will include a text book and require study between sessions one and two. |
| Speaker | Carol Mallia RN, MSN |
| Date | Sept. 6 and 20, 2005 |
| Time | 9 a.m. – 2 p.m. (light lunch provided) |
| Place | MNA Headquarters, Canton |
| Fee | MNA Members $90; all others $125 |
| Contact Hours* | 9.0 |
| MNA Contact | Theresa Yannetty, 781-830-5727 or 800-882-8056, x727 |

### Emergency Medical Response to Hazardous Materials and Acts of Terrorism

| Description | The Massachusetts Emergency Management Agency (MEMA) is sponsoring this program on emergency medical services in response to Hazardous Materials and acts of Terrorism. The program is specifically designed for Physicians, Nurses and EMT’s and Hospital Support Staff to provide education in the treatment of individuals exposed to chemical and biological agents. Program will include identification of hazardous materials, toxicological and biological effects of chemicals and biological acts of terrorism. The chemical profile of common agents, decontamination procedures, and personal protective equipment will be discussed. CDC guidelines for surveillance of exposed nurses and other healthcare workers and nursing interventions for patient care will be identified. Class size is limited to 25 participants per session. Please reserve your space early. |
| Speaker | Anthony Fucaloro EMT |
| Date | Sept. 19, 2005 |
| Time | 9 a.m. – 5 p.m. (light lunch provided) |
| Place | MNA Headquarters, Canton |
| Fee | MNA Members $45; all others $65 |
| Contact Hours* | 6.9 |
| MNA Contact | Susan Clish, 781-830-5723 or 800-882-2056, x723 |

### Advance Cardiac Life Support (ACLS)

| Description | This American Heart Association course will provide information on the clinical management of cardiac and respiratory emergencies through case study approach. Course content includes assessment, arrhythmia recognition, intubation, defibrillation and pharmaceutical interventions. This is a two-day certification and a one-day recertification. Recertification candidates must present a copy of their current ACLS card at the time of registration. |
| Speaker | Carol Mallia RN, MSN and other instructors for the clinical sessions |
| Date | Oct. 11 & 18, 2005 |
| Time | 9 a.m. – 5 p.m. (light lunch provided) |
| Place | MNA Headquarters, Canton |
| Fee | MNA Members $155 members, $195 others Re-Certification: $125 members, $165 others |
| Contact Hours* | 16 Contact Hours for certification only |
| MNA Contact | Liz Chmielinski, 781-830-5719 or 800-882-2056, x719 |

### Diabetes 2005: What Nurses Need to Know

| Description | This program will discuss the pathophysiology and classification of Diabetes Type 1 and 2. Nursing implications of blood glucose monitoring, non-pharmaceutical interventions such as exercise and meal planning will be addressed. Oral pharmaceutical agents and a comprehensive update on insulin therapy will be presented. The nursing management of the newly diagnosed diabetic patient, both complicated and not, will be explored. |
| Speaker | Ann Miller, MS, RN, CS, CDE, Legal Nurse Consultants, Southern New England Chapter of the American Association of Legal Nurse Consultants |
| Date | Oct. 27, 2005 |
| Time | 8:30 a.m. – 4 p.m. (lunch will be provided) |
| Place | MNA Headquarters, Canton |
| Fee | MNA Members $125; all others $150 |
| Contact Hours* | 7.2 |
| MNA Contact | Liz Chmielinski, 781-830-5719 or 800-882-2056, x719 |

### Interpreting Laboratory Values

| Description | This program will enhance the nurse’s ability to evaluate and determine the clinical significance of laboratory values. Clinical case studies will be used to illustrate the relationship of laboratory values to patient conditions. Clinical management of abnormal laboratory values will be discussed. |
| Speaker | Carol Mallia RN, MSN |
| Date | Nov. 1, 2005 |
| Time | 8:30 a.m. – 4 p.m. (lunch will be provided) |
| Place | MNA Headquarters, Canton |
| Fee | MNA Members $90; all others $125 |
| Contact Hours* | 7.2 |
| MNA Contact | Theresa Yannetty, 781-830-5727 or 800-882-8056, x727 |

### Nurse Protect Thyself ... Tool Kit for Nursing Practice

| Description | This program will provide nurses with a tool kit of information to minimize liability in nursing practice situations. The elements of negligence and how nurses are accountable through regulations, scope of practice and standards of care will be addressed. Documentation and its uses in litigation will be discussed and strategies provided to protect your nursing practice. |
| Speakers | Legal Nurse Consultants, Southern New England Chapter of the American Association of Legal Nurse Consultants |
| Date | Nov. 4, 2005 |
| Time | 9 a.m. – 2 p.m. (light lunch provided) |
| Place | MNA Headquarters, Canton |
| Fee | MNA Members $TBA; all others $TBA |
| Contact Hours* | To be provided |
| MNA Contact | Liz Chmielinski, 781-830-5719 or 800-882-2056, x719 |

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**MORE FALL C.E. COURSES, NEXT PAGE**

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**All MNA programs are free of charge to Region 5 members**
Oncology for Nurses

**Description**
This program will increase knowledge in oncology nursing. The content of the program will include an overview of cancer management, tumor physiology and staging, relevant laboratory testing and treatment strategies and safe handling of neoplastic agents. Chemotherapy administration, classification of chemotherapeutic agents, management of toxicities and adverse effects of treatments and oncological emergencies will be discussed. The program will conclude with pain and symptom management, palliative care and an overview of Hospice care.

**Speaker**
Marylou Gregory-Lee MSN, RNCS, OCN, Adult Nurse Practitioner

**Date**
Nov. 9, 2005

**Time**
8:30 a.m. – 4 p.m. (light lunch provided)

**Place**
MNA Headquarters, Canton

**Fee**
MNA Members $125; all others $150

**Contact Hours**
7.2

**MNA Contact**
Liz Chmielinski, 781-830-5719 or 800-882-8056, x719

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Cardiac and Pulmonary Pharmacology

**Description**
This program will provide nurses from all clinical practice settings a better understanding of how cardiac and pulmonary medications work. The actions, indications, and nursing considerations will be discussed for the major categories of cardiac and pulmonary medications.

**Speaker**
Carol Malia RN, MSN

**Date**
December 6, 2005

**Time**
5–9 p.m. (light supper provided)

**Place**
MNA Headquarters, Canton

**Fee**
MNA Members $45; all others $65

**Contact Hours**
3.6

**MNA Contact**
Theresa Vannetty, 781-830-5727 or 800-882-8056, x717

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**CONTINUING ED COURSE INFORMATION**

**Registration**
Registration will be processed on a space available basis. Enrollment is limited for all courses.

**Payment**
Payment may be made with MasterCard or Visa by calling the MNA contact person for the program or by mailing a check to MNA, 340 Tumpike St., Canton, MA 02021.

**Refunds**
Refunds are issued up to two weeks before the program date minus a 25% processing fee. No refunds are made less than 14 days before the program's first session or for subsequent sessions of a multi-day program.

**Program Cancellation**
MNA reserves the right to change speakers or cancel programs when registration is insufficient. **In case of inclement weather**, please call the MNA at 781-821-4625 to determine whether a program will run as originally scheduled. Registration and fees will be reimbursed for all cancelled programs.

**Contact Hours**
Continuing Education Contact Hours for all programs except “Advanced Cardiac Life Support” are provided by the Massachusetts Nurses Association, which is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation. Contact hours for “Advanced Cardiac Life Support” are provided by the Rhode Island State Nurses Association, which is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

To successfully complete a program and receive contact hours or a certificate of attendance, you must:
1) sign in,
2) be present for the entire time period of the session and
3) complete and submit the evaluation.

**Chemical Sensitivity**
Scents may trigger responses in those with chemical sensitivity. Participants are requested to avoid wearing scented personal products and refrain from smoking when attending MNA continuing education programs.

MNA membership dues deductibility 2004

Below is a table showing the amount and percentage of MNA dues that may not be deducted from federal income taxes. Federal law disallows the portion of membership dues used for lobbying expenses.

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<thead>
<tr>
<th>Region</th>
<th>Amount</th>
<th>Percent</th>
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<tr>
<td>All Regions</td>
<td>$16.63</td>
<td>5.0%</td>
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**The Massachusetts Nurses Association joins MITSS to provide support for nurses as a result of an adverse medical event.**

**“To Support Healing & Restore Hope”**

**Program Mission/Philosophy**
- We believe that nurses have a professional responsibility to support colleagues who have been affected by unexplained medical outcomes or adverse patient events.
- We believe that early support can lessen the emotional effects on the nurse clinician provider.
- Are you a nurse who has been impacted emotionally by an experience associated with an adverse medical outcome?
- Would you like to talk confidentially to a MITSS therapist?
- Join in a peer-led support group?
- Would you like to join or participate in a structured support group led by an experienced psychologist?

**Medically Induced Trauma Support Services (MITSS), Inc.** is a non-profit organization that supports, educates, trains, and offers assistance to individuals affected by medically induced trauma.

**MITSS supports clinicians using the following resources:**
- One-on-one interaction via phone
- Group sessions led by a professional facilitator
- Training for fellow survivors who would like to help others

**MITSS Toll-Free Number**
888-36-MITSS

**MITSS Referral Line**
781-821-4625, x.770

**MITSS Web Site**
http://mitss.org

This service is available to any RN in Massachusetts.
10,000 nurses for a constitutional right to affordable health care

We're sponsors of the Health Care for Massachusetts Campaign—a citizen-led initiative to create a constitutional right to affordable, comprehensive health and mental health care for every Massachusetts resident. And we're hoping you'll join us in transforming our health care system.

We've endorsed, the MNA has endorsed, 71,385 voters have endorsed, 52 legislators have co-sponsored and 153 legislators voted for the Amendment in the July 14 Constitutional Convention. **We're half-way to putting this historic amendment on the ballot in 2006.**

We're looking for 10,000 nurses to join us so when we go to the Legislature next session to lobby for the critical second vote we need to put the amendment on the ballot every legislator will know—in no uncertain terms—how important universal health care is to the nurses of Massachusetts.

Join the 10,000 nurse campaign. Endorse yourself and sign up 19 of your co-workers. Then fax it back to the Campaign at 617-868-1363. It just takes a few minutes

Thanks so very, very much.

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**Benefits Corner**

**MNA offers choice of cell phone programs**

**Verizon Wireless 617-571-4626**

- 8 percent discount off any price plan $34.99 and above. Free Motorola V60s on any new purchase or upgrade. Wide selection of other phones & plans to choose from with special pricing for MNA members, including any time minutes & many other features. Contact Carol or email carol.mogaro@verizonwireless.com

**Cingular Wireless 781-690-5368**

- As an MNA member, you & your family can enjoy the convenience & safety of owning a cellular telephone. Save 10–20 percent off SuperHome rate plans with no activation fee plus 20 percent discount on accessories. Some plans include free nights (9 p.m. – 7 a.m.) and free weekends.

**Nextel Communications 617-839-6684**

- As a MNA member, you and your family can enjoy Free Incoming call plans and Direct Connect! Save 10 percent on all rates and 30 percent off all equipment! Enjoy the ability to talk to all friends and co-workers with a push of a button! Many phones to choose from including the new 1830 and the new Blackberry 7510! Please call Mark, Patty or Don or visit their Web site at www.nextel.com/massnurses

**Important information regarding utilizing MNA benefits**

MNA has negotiated discounts and savings with several vendors to offer discounts and services specifically designed for MNA members. It is very important that you only contact the specific representative at the telephone number listed on publications or flyers produced by the MNA. These individuals are familiar with the MNA negotiated discounts and are authorized to provide discounts to members in good standing.

All benefits and discounts are subject to change. Up-to-date information on all MNA benefits and contacts are available on the MNA website at www.massnurses.org/member/ or by contacting Chris Stetkiewicz in the Membership Department at 781-821-4625 x726 or email membership@mnarn.org

**Financial savings available to MNA members**

The MNA is proud to offer services to financially benefit our members. The financial savings available to members is tremendous. The cost of membership is directly offset when you take advantage of any of our money savings programs.

Take a look at some of the financial services available to you as a member:

**MNA home mortgage program**

Reliant Mortgage Company has created a program to help members obtain mortgages with significant discounts on closing costs and points. Members are entitled to $275 off closing costs, 1/8 point discount off points incurred, and assistance in refinancing to save hundreds of dollars a month on your current mortgage. You are also entitled to free purchase & sales agreement review, free mortgage pre-approval, free credit analysis and the services of a home mortgage consultant available to guide you step-by-step through the mortgage process. Call the MNA Home Mortgage Answer Line toll free at 877-662-6623.

**Auto/homeowners insurance discounts**

Our agreement with Colonial Insurance Services, Inc. affords members savings on auto and homeowners insurance. The savings of 6 percent on Massachusetts auto rates is significant! No service fee is charged when choosing their automatic EFT payment plan. Our discount is competitive with AAA and is available to all household members. Your savings is increased to a 12 percent account credit when you utilize Colonial for both your auto and homeowners insurance needs. A no obligation quote is available at www.colonialinsuranceservices.com or by contacting Colonial directly at 800-571-7773.

**Tax review service**

MNA is happy to offer the services of AccuTax, a trusted, highly ethical company dedicated to reviewing your last three years of tax returns to ensure that you've taken advantage of every deduction. Allow experts to review your tax returns with a no-risk plan – no refund, no charge. You may have unknowingly overpaid taxes and have a refund waiting to be claimed. For more information regarding this service contact David Dunn at Merriam Tax Recovery at 508-340-0240.

**MBNA credit card program**

Need credit? Apply for the MNA credit card issued by MBNA America, N.A. It's the only credit card endorsed by the MNA and offers competitive annual percentage rates for purchases and cash advances. To apply, contact MBNA at 800-847-7378.

For more information about any of the programs listed as well as MNA money saving programs on products, services, travel & leisure visit the MNA website at www.massnurses.org/member/ or contact the MNA at 781-821-4625, x726.
Diversity Corner

Tsunami relief assistance needed

Several humanitarian organizations are currently conducting relief efforts for victims of the devastating Indian Ocean tsunami. Those interested in assisting these efforts are encouraged to visit www.usafreedomcorps.gov and find out how best to help.

Join the Bargaining Unit Challenge

MNF Golf Tournament

Brookmeadow Country Club

Thursday, JUNE 23

Canton, Massachusetts

- Compete in the Bargaining Unit Challenge - an award will be given to the unit with the best score!
- Cash Awards & Prizes for Men's, Women's & Mixed.
- Hole-In-One Prizes!
- Raffle and Awards!

FOR MORE INFORMATION OR TO REGISTER A FOURNSOME

781-830-5745

Support Groups for Nurses and Other Health Professionals with Substance Abuse Problems

Below is a list of self-help groups facilitated by volunteer nurses who understand addiction and the recovery process. Many nurses with substance abuse problems find it therapeutic to share their experiences with peers who understand the challenges of addiction in the health care profession.

Boston Metropolitan Area

- Bournemoth Hospital, Health Care Professionals Support Group, 300 South St., Brookline. Contact: Donna White, 617-469-0300, x305. Meets: Wednesdays, 7:30–8:30 p.m.
- McLean Hospital, DeMarnelle Building, Room 116. Contact: LeRoy Kelly, 508-881-3192. Meets: Thursdays, 5:30–6:30 p.m.
- Peer Group Therapy, 1354 Hancock Street, Suite 209, Quincy. Contact: Terri O’Brien, 781-340-0405. Meets: Tuesdays & Wednesdays, 5:30 p.m. & coed Wednesdays, 7 p.m.
- Caritas Good Samaritan Medical Center, Community Conference Room, 235 N. Pearl St., Brockton. Contact: Eleanor O’Flaherty, 508-559-8897.

Meets: Fridays, 6:30-7:30 p.m.
- Health Care Professional Support Group, Caritas Norwood Hospital, Norwood. Contact: Jacqueline Sitte, 781-341-2100. Meets: Thursdays, 7–8:30 p.m.
- Health Care Support Group, UMass School of Medicine, Room 123, Worcester. Contact: Emory, 508-429-9433.
- Partnership Recovery Services, 121 Myrtle Street, Melrose. Contact: Jay O’Neil, 781-979-0262. Meets: Sundays 6:30–7:30 p.m.

Western Massachusetts

- Professionals in Recovery, Baystate VNAH/EAP Building, Room 135, 50 Maple St., Springfield. Contact: Marge Babkiewicz, 413-794-4354. Meets Thursdays, 7:15–8:15 p.m.

Southern Massachusetts

- Professionals Support Group, 76 W. Main St., Suite 306, Hyannis. Contact: Kathy Hoyt, 508-780-1944. Meets: Mondays, 5–6 p.m.
- PRN Group, Pembroke Hospital, 199 Oak Street, Staff Dining Room, Pembroke. Contact: Sharon Day, 508-375-6227. Meets: Tuesdays, 6:30–8 p.m.
- Substance Abuse Support Group, St. Luke’s Hospital, New Bedford, 88 Faunce Corner Road. Contact: Michelle, 508-947-5351. Meets: Thursdays, 7–8:30 p.m.

Other Areas

- Maguire Road Group, for those employed at private health care systems. Contact: John William, 508-834-7036. Meets: Mondays.
- Nurses Recovery Group, VA Hospital, 5th Floor Lounge, Manchester, N.H. Contacts: Diede M., 603-647-8852, Sandy, 603-666-6482. Meets: Tuesdays, 7–8:30 p.m.
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